

**IN THE DISTRICT COURT OF JOHNSON COUNTY, KANSAS  
CIVIL COURT DEPARTMENT**

HODES & NAUSER, MDs, P.A., on )  
behalf of itself, its patients, physicians, )  
and staff; TRACI LYNN NAUSER, )  
M.D.; and COMPREHENSIVE )  
HEALTH OF PLANNED )  
PARENTHOOD GREAT PLAINS, on )  
behalf of itself, its patients, physicians, )  
and staff, )

*Plaintiffs,*

v.

KRIS KOBACH, in his official capacity )  
as Attorney General of the State of )  
Kansas; STEPHEN M. HOWE, in his )  
official capacity as District Attorney for )  
Johnson County; MARC BENNETT, in )  
his official Capacity as District )  
Attorney for Sedgwick County; MARK )  
A. DUPREE SR., in his official capacity )  
as District Attorney for Wyandotte )  
County; the STATE OF KANSAS ex )  
rel. Kansas State Board of Healing )  
Arts; and JANET STANEK, in her )  
official capacity as Secretary of the )  
Kansas Department of Health and )  
Environment, )

*Defendants.*

Case No. 23CV03140

Division No. 12  
K.S.A. Chapter 60

**STATE DEFENDANTS' PROPOSED FINDINGS OF FACT AND  
CONCLUSIONS OF LAW**

State Defendants respectfully submit that the Court should find and conclude as follows in the trial of this matter:

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## INTRODUCTION

Abortion is one of the most contested political, moral, and ethical issues of the last century. Even Plaintiffs agree that abortion presents unique medical, ethical, personal, and political concerns—as Dr. Nauser testified, “abortion is not a happy situation ... most of the time.” 9/26/25 PM Tr. at 40:1–21 (Nauser). And while the Kansas Supreme Court has recognized a right to bodily autonomy that encompasses a woman’s right to choose an abortion, it has also disclaimed the notion that any regulation of abortion infringes that right—the right is “not absolute.” *Hodes & Nauser, MDs, P.A. v. Stanek*, 318 Kan. 995, 1014, 551 P.3d 62, 77 (2024). The Kansas Supreme Court has instead determined that a law concerning abortion violates the right of bodily autonomy if it prevents a woman from exercising her choice to keep or end her pregnancy. *Hodes & Nauser, MDs, P.A. v. Schmidt*, 309 Kan. 610, 672, 440 P.3d 461, 498 (2019).

After consideration of the extensive trial record developed in this case, the Court finds that Plaintiffs have failed to prove that any provision of the Woman’s Right to Know Act (WRTKA) violates the right to autonomy. To the contrary, Defendants’ experts in epidemiology and ethics showed that it promotes that right. The WRTKA provides women with relevant and scientifically accurate disclosures about abortion that third-party witnesses in this case said they wish they had received before their abortions. Even Plaintiffs admitted that some women choose differently after receiving these disclosures.

Plaintiffs did not even attempt to prove that most of those provisions caused any harm to women’s autonomy, and their experts admitted that key aspects of many provisions of the Act do not infringe autonomy and that its disclosures are relevant and true. Plaintiffs’ case instead centered on the alleged delay they say was caused by the WRTKA’s written disclosures provided to patients 24 hours before their appointments. But the WRTKA did not cause the harms alleged by

Plaintiffs. Plaintiffs' testimony showed that they could have complied with the law in other ways—for example, by sending the written disclosures via expedited mail—that would have caused no such delay.

Plaintiffs' free-speech claims fail for related reasons. Because the disclosures required by the WRTKA are supported by reliable scientific evidence, they are regulations of speech incidental to conduct that do not violate free speech. Further, as Plaintiffs admitted at trial, the speech at issue is the government's, not theirs, and they provide competing disclosures whenever they disagree with the government's message. Neither does the law violate equal protection, since the regulation of a procedure that only one sex can undergo is not sex discrimination.

Nor is there any merit to Plaintiffs' challenge to H.B. 2749. Consistent with many other state public health initiatives, including those of New York and Washington, H.B. 2749 collects important public health data on the reasons women seek abortion. The only third-party witnesses in this case who had abortions testified that they would not be harmed, offended, or otherwise stigmatized by those questions. Finally, the law can be implemented without requiring any speech by Plaintiffs, and even if it did regulate speech by Plaintiffs, it is speech incidental to conduct.

Plaintiffs have failed to prove these laws infringe any constitutional right, which means they are subject to rational basis review. They pass that deferential standard. The Court therefore vacates its temporary injunction and directs the entry of judgment for Defendants.

## **FINDINGS OF FACT**

### **I. The Challenged Statutes.**

1. Plaintiffs challenge three statutes in this litigation: the Woman's Right to Know Act (WRTKA), H.B. 2264, and H.B. 2749. The Court granted a temporary injunction against the WRTKA and H.B. 2264 during the pendency of this litigation,

and the parties stipulated Defendants would not enforce H.B. 2749 pending a final judgment, which the Court so-ordered. The Court conducted a trial on Plaintiffs' challenges to these statutes in September and October of 2025.

**A. The Woman's Right to Know Act.**

2. Enacted in 1997, the WRTKA provides that no abortion shall be performed without informed consent of the patient and establishes various statutory procedures that constitute informed consent. K.S.A. 65-6709. Those procedures include that a woman seeking an abortion be provided with certain information in writing and on paper 24 hours before the abortion, *see id.* 65-6709(a), (d), as well as that she be allowed to speak with the physician who performs the abortion 30 minutes in advance, *id.* 65-6709(c), and that abortion clinics display certain signage disclosing information about the abortion procedure, *id.* 65-6709(k). The WRTKA is enforceable through professional discipline, with knowing, intentional, or reckless violations constituting unprofessional conduct, *id.* 65-6712, and through private tort actions by women who did not receive the disclosures. *See, e.g., Kelly v. VinZant*, 287 Kan. 509, 519 (2008). Further, the WRTKA contains a severability clause. K.S.A. 65-6714.

**B. H.B. 2264.**

3. In 2023, the Kansas legislature amended the WRTKA to add H.B. 2264, a new provision requiring disclosure of certain information regarding the possibility of reversing a drug-induced abortion. H.B. 2264 requires a physician providing an abortion to disclose that mifepristone alone is not always effective in ending a pregnancy, that it may be possible to reverse the effects of mifepristone if one acts quickly, and that organizations exist to provide this intervention. K.S.A. 65-6716(b)(1). The new statute is enforceable via criminal penalties, the Kansas Department of Health and Environment (KDHE), and a private right of action by the woman or related persons. *Id.* 65-6716(f)–(h).

**C. H.B. 2749.**

4. In 2024, through passage of H.B. 2749, the Kansas legislature amended its abortion-reporting law to require collection of data on the reasons women seek abortion. In relevant part, the statute provides that a woman who obtains an abortion “shall be asked” to select the most important factor for her decision to obtain an abortion from a list of eleven options. K.S.A. 65-445(c). The question is voluntary for the woman to answer, and abortion clinics are required to report the data they receive to KDHE, along with other demographic information. K.S.A. 65-445(d)–(e).

**II. Plaintiffs and their employees.**

5. Plaintiff Comprehensive Health of Planned Parenthood Great Plains (“Comprehensive Health”) operates abortion clinics in Kansas City, Overland Park, Wichita, and Pittsburgh, Kansas.

6. Emily Wales, a lawyer by training who testified at trial, is the President and CEO of Comprehensive Health. She testified as a corporate representative for Comprehensive Health and explained the steps Comprehensive Health took to comply with the WRTKA.

7. Dr. Iman Alsaden is the Chief Medical Officer of Comprehensive Health. Dr. Alsaden testified as a fact and expert witness.

8. Dr. Selina Sandoval is the Associate Medical Director of Comprehensive Health. She was called by the State Defendants and testified regarding the wait times at Comprehensive Health clinics and the videos Comprehensive Health shows their patients as part of the informed-consent process.

9. Angela Huntington worked as a patient navigator for Comprehensive Health from 2021 to 2024. She testified that Planned Parenthood and

Comprehensive Health provided financial assistance to patients who could not afford to travel to a clinic for an abortion.

10. Plaintiff Hodes & Nauser, MDs, P.A. operates an abortion clinic in Overland Park, Kansas, under the name Center for Women’s Health.

11. Plaintiff Dr. Traci Lynn Nauser is the owner of Hodes & Nauser and a physician at the Overland Park clinic. 9/26/25 AM Tr. at 17:5–6 (Nauser). She testified as a fact and expert witness, as well as in the capacity of the corporate representative for Hodes & Nauser.

12. Lynette Ranney was a facilities manager at Hodes & Nauser from 2018 to November 2023. 10/14/25 AM Tr. at 25:14–17 (Ranney). In that role, she was “responsible for ensuring compliance with the Woman’s Right to Know Act.” 10/14/25 AM Tr. at 25:21–24 (Ranney). She testified about Hodes & Nauser’s interaction with patients under the WRTKA.

### **III. Defendants.**

13. Plaintiffs sued Defendant Kris Kobach in his official capacity as Attorney General of the State of Kansas, Defendant Stephen M. Howe in his official capacity as District Attorney for Johnson County, Defendant Marc Bennett in his official capacity as District Attorney for Sedgwick County, and Defendant Mark A. Dupree Sr. in his official capacity as District Attorney for Wyandotte County. These defendants are referred to as the State Defendants, or more generally as Defendants.

14. Plaintiffs also sued Defendant the Kansas State Board of Healing Arts and Defendant Janet Stanek in her official capacity as Secretary of the Kansas Department of Health and Environment. These defendants introduced no evidence at trial.

#### **IV. Abortion.**

15. The Court finds that abortion entails serious medical and mental-health risks, and presents ethical issues unique from other medical procedures, including potential coercion.

##### **A. Abortion entails serious medical risks.**

16. The Court finds there are serious medical risks associated with both drug-induced and surgical abortion.

17. Plaintiffs presented expert testimony on the risks of abortion from physicians who work for Plaintiffs in this case: Dr. Traci Nauser (for Hodes & Nauser) and Dr. Iman Alsaden (for Comprehensive Health). Defendants presented the expert testimony of Dr. Monique Chireau Wubbenhorst, an obstetrician-gynecologist, on the epidemiology of abortion. 10/15/25 AM Tr. at 91:21–22 (Wubbenhorst). For the reasons that follow, the Court finds Defendants’ expert testimony on this point more persuasive than the expert testimony of Plaintiffs.

18. Understanding the risks of abortion is a question of epidemiology, “the study of the distribution of patterns of disease and injury in human beings.” 10/15/25 AM Tr. at 93:5–7 (Wubbenhorst). While neither Dr. Nauser nor Dr. Alsaden claimed any expertise in epidemiology, Dr. Wubbenhorst is highly qualified to testify on the epidemiology of abortion. She earned a medical degree from Brown University, and a master’s degree in public health from Harvard University. 10/15/25 AM Tr. at 92:14–93:1 (Wubbenhorst); DX117 at 1–2. Her master’s degree focused on biostatistics and epidemiology. 10/15/25 AM Tr. at 93:2–7 (Wubbenhorst). Dr. Wubbenhorst completed postdoctoral fellowships at the University of North Carolina and the Durham VA Center of Excellence in Women’s Health. 10/15/25 AM Tr. at 92:14–93:1 (Wubbenhorst); DX117 at 1–2. Dr. Wubbenhorst has also held faculty appointments at Harvard Medical School, the University of North Carolina-Chapel Hill, Duke University Medical Center, and

Indiana University Medical School. 10/15/25 AM Tr. at 93:8–14 (Wubbenhorst); DX117 at 2.

19. Dr. Nauser has not performed or published original research on the issues in this case. *See* 9/26/25 AM Tr. at 125:3–13 (Nauser). However, Dr. Wubbenhorst has performed extensive research on adverse pregnancy outcomes and maternal care, having received seven research grants and awards during her career. 10/15/25 AM Tr. at 94:6–16, 95:22–97:1 (Wubbenhorst); DX117 at 13–14. Dr. Wubbenhorst’s research has been published in multiple journals, including the *Journal of the American Medical Association* and the journal of the American College of Obstetricians and Gynecologists (ACOG) called “Obstetrics & Gynecology” or the “Green Journal,” which is “one of the premier[] journals” in the field. 10/15/25 AM Tr. at 97:2–20 (Wubbenhorst); DX117 4–6.

20. The Court further finds that Dr. Wubbenhorst’s methods were more reliable than those of Dr. Nauser and Dr. Alsaden. Dr. Nauser was unable to describe her method or to explain the concept of falsification in science. Deposition of Traci Lynn Nauser, M.D., 22:13–27:15 (“Nauser Dep.”). In at least one instance, Dr. Alsaden formed an opinion on a key medical issue in this case by reading one article, without looking at contrary findings in the literature. 9/26/25 PM Tr. at 111:5–18; 9/29/25 AM Tr. at 15:6–21. In contrast, Dr. Wubbenhorst conducted a literature review using “the snowball method,” which involved searching multiple medical-science databases with “key words” to identify relevant articles, analyzing the reliability of their methods and conclusions, and reviewing the studies they cited. 10/15/25 AM Tr. at 103:21–104:25 (Wubbenhorst). “[T]hen that process would continue iteratively.” 10/15/25 AM Tr. at 103:21–104:25 (Wubbenhorst). This is “a standard method.” 10/15/25 AM Tr. at 105:1–3 (Wubbenhorst); *see also* 10/15/25 PM Tr. at 29:22–31:2 (Wubbenhorst) (discussing steps to avoid bias and confounding).

21. Dr. Wubbenhorst explained that U.S. data on abortion is subject to “very well known” risks of bias and confounding. 10/15/25 PM Tr. at 29:22–31:2 (Wubbenhorst). The Centers for Disease Control (CDC) acknowledged in its abortion-surveillance report that it is unable to ascertain the total number of abortions in the United States, particularly since reporting is voluntary and not all states report. 10/15/25 PM Tr. at 29:22–31:2 (Wubbenhorst). Further, there exists no “formal or medical[] reporting requirement for abortion complications,” which means women may be seen for abortion complications without any reporting of the reason for the complication. 10/15/25 PM Tr. at 29:22–31:2 (Wubbenhorst). In addition, “follow-up at abortion clinics is understood to be low”; a study from ACOG shows it ranges “from 30 to 50 to 60 percent.” 10/15/25 PM Tr. at 29:22–31:2 (Wubbenhorst). These problems also affect the reliability of the U.S. label for mifepristone. 10/15/25 PM Tr. at 40:8–20 (Wubbenhorst).

22. Thus, to evaluate the real risks of abortion in a population, studies done in Scandinavian countries like Finland are “the gold standard.” 10/15/25 PM Tr. at 31:23–32:12 (Wubbenhorst). That is because “in the Finnish system, you enter the health system as a baby and you exit the health system ... when you die,” so epidemiologists have “access to all of the interactions that the patient had with the medical system” throughout the patient’s life. 10/15/25 PM Tr. at 31:23–32:12 (Wubbenhorst). A leading Scandinavian study by Dr. Maarit Niinimaki published in ACOG’s Green Journal examined the rates of adverse outcomes from drug-induced abortion and surgical abortion. 10/15/25 PM Tr. at 32:13–23 (Wubbenhorst); see DX162. The study showed that the risk of an adverse outcome from a pregnancy termination was higher for women who underwent “medical” abortions compared to “surgical” abortions. 10/15/25 PM Tr. at 33:19–34:13 (Wubbenhorst); DX162 at 795. Niinimaki found that approximately six percent of women who underwent a drug-induced abortion had to subsequently have a surgical abortion to remove retained

placental parts. 10/15/25 PM Tr. at 33:19–34:13 (Wubbenhorst); DX162 at 795. The adverse events described in the paper, such as “[b]leeding, perforation of the uterus, death, [and] infections” were “measurable events that are linked to” abortion and emergency room visits rather than mere “consultations or complications.” 10/15/25 PM Tr. at 117:2–118:1, 133:5–134:22 (Wubbenhorst); *accord* 10/17/25 AM Tr. at 44:16–45:1 (Curlin).

23. Dr. Wubbenhorst also offered un rebutted testimony based on a study by Dr. Linda Bartlett published in the Green Journal in 2004 that the medical risks of abortion increase with gestational age. 10/15/25 PM Tr. at 35:10–36:2, 40:21–41:4, 40:21–41:4, 41:11–13 (Wubbenhorst); DX163. The study found that “the risk of death increased by 38 percent exponentially with every week of gestational age.” 10/15/25 PM Tr. at 35:10–36:2 (Wubbenhorst). “If you carry those numbers out” to abortion in the late third trimester, “you’re looking at astronomical rates of ... mortality”—substantially higher than the maternal-mortality rate in the United States. 10/15/25 PM Tr. at 138:3–23 (Wubbenhorst). The authors noted that those risks are “probably not amenable to being modified because of the greater technical problems associated with abortion at higher gestational age.” 10/15/25 PM Tr. at 35:10–36:2 (Wubbenhorst).

24. Plaintiffs themselves acknowledge some of these medical risks. Dr. Nauser testified that the epidemiological literature shows that “[t]he further the gestation age, the more potential risks of complications or problems during the procedure.” Nauser Dep. 109:13–110:4. Dr. Nauser has had patients taken “to the hospital because of complications during the procedure.” Nauser Dep. 311:20–313:17. One was for “bleeding out,” another was for a “uterine perforation,” and a third was for pain surrounding a C-section. Nauser Dep. 311:20–313:17.

25. Planned Parenthood received similar complaints. One patient complained of experiencing “contractions much like when having a baby,” and had

to “[try] not to pass out from the pain.” 9/30/25 AM Tr. at 93:21–94:8 (Wales). One patient experienced weeks-long bleeding and had to have multiple procedures, DX109, another experiencing hemorrhaging and required emergency surgery, DX111, and a third had to be hospitalized for an infection and required respiration, DX115.

26. In contrast, Dr. Nauser testified that drug-induced abortion is safer than common pain-relievers like Tylenol. 9/26/25 AM Tr. at 36:18–22 (Nauser). But Dr. Wubbenhorst explained several reasons why that claim lacks scientific support. 10/15/25 PM Tr. at 37:23–38:4 (Wubbenhorst). The FDA label for the abortion drug mifepristone, unlike the over-the-counter label for Tylenol, has a “black box warning,” which exists to “inform clinicians of significant risks of death or serious injury from the prescribed use of medication.” 10/15/25 PM Tr. at 38:6–39:1, 39:10–15 (Wubbenhorst). No study directly compares mifepristone to Tylenol, and it is unlikely there will ever be one. 10/15/25 PM Tr. at 37:23–39:1 (Wubbenhorst). Most adverse outcomes associated with Tylenol occur because of overdose, while mifepristone poses “problems of bleeding, infection, hemorrhage, sepsis[, and] retained fetal and placental parts” that are “inherent to the use of the drug.” 10/15/25 PM Tr. at 38:6–39:1 (Wubbenhorst). And because of the risks associated with mifepristone, the FDA has put in place a series of special safeguards that do not exist for Tylenol. 10/15/25 PM Tr. at 39:25–40:7 (Wubbenhorst).

27. Dr. Alsaden also relied on a study, *Incidence of Emergency Department Visits and Complications After Abortion*, that purports to show low medical risks of abortion. 10/15/25 PM Tr. at 37:3–17, 70:21–71:17 (Wubbenhorst); DX170. But Dr. Wubbenhorst explained the study had “some significant flaws which are actually acknowledged by [the] authors.” 10/15/25 PM Tr. at 37:3–17, 70:21–71:17 (Wubbenhorst); DX170. Its results were inconsistent with those from “much more complete databases such as the Finish database.” 10/15/25 PM Tr. at 70:21–71:17

(Wubbenhorst). It also “focus[ed] on shorter term complications and not so much the longer term complications.” 10/15/25 PM Tr. at 71:18–74:17 (Wubbenhorst). And the study was “unable to determine the exact week of gestation of each abortion, which is known to be a strong predictor of complications risk.” DX170 at 182; 10/15/25 PM Tr. at 71:18–74:17 (Wubbenhorst).

28. Dr. Nauser relied on reports by the National Academy of Sciences about the purportedly low risks of abortion. 9/26/25 AM Tr. at 37:1–42:11 (Nauser) (discussing PX068). However, that report “excluded a large number of studies with no apparent explanation” and “focused principally on studies that reported no adverse outcomes to be associated [with] abortion.” 10/15/25 PM Tr. at 66:17–67:2 (Wubbenhorst). In addition, the research was “funded by the Warren Buffett foundation and other organizations which promote abortion internationally and domestically,” which could cause bias. 10/15/25 PM Tr. at 66:17–67:8 (Wubbenhorst).

**B. Abortion entails serious mental-health risks.**

29. The Court finds that abortion can cause serious adverse mental-health outcomes.

30. To begin, Dr. Wubbenhorst offered testimony that many abortions are not regarded by the patient as fully voluntary. She first relied on a study by Dr. David Reardon and others called *The Effects of Abortion Decision Rightness and Decision Type on Women’s Satisfaction and Mental Health*. 10/15/25 PM Tr. at 16:18–17:10 (Wubbenhorst); DX161 at 1. Surveying over a thousand women, the study found that “24 percent of women stated that their abortions were unwanted or coerced, 33 percent of women stated that their abortions were wanted[,] and 60 percent of women said they would have given birth with emotional or financial support.” 10/15/25 PM Tr. at 17:20–18:3 (Wubbenhorst); *see also* DX161 at 1. This

showed that “a significant portion of abortions are coerced or unwanted.” 10/15/25 PM Tr. at 22:22–23:15 (Wubbenhorst).

31. Dr. Wubbenhorst also relied on an article by Dr. Priscilla Coleman and others called *Women Who Suffered Emotionally from Abortion: A Qualitative Synthesis of Their Experiences*, published in the *Journal of American Physicians and Surgeons*. 10/15/25 PM Tr. at 18:12–21 (Wubbenhorst); DX161 at 2. Coleman performed a qualitative research study allowing women to talk about their abortion experiences. 10/15/25 PM Tr. at 18:22–19:1 (Wubbenhorst). Of the women interviewed, “58.3 percent ... reported aborting to make others happy[,] 73.8 percent said [their] abortion was not free from even subtle pressure to abort[,] 28.4 percent aborted out of fear of losing their partner[,] 49.2 percent reported believing that the fetus wasn’t a human being[,] 66 percent said they knew in their hearts that they were making a mistake[, a]nd 33.2 percent felt emotionally connected to the fetus before the abortion.” 10/15/25 PM Tr. at 19:1–12 (Wubbenhorst); DX161 at 2. This study shows that the “women felt pressured to undergo abortion,” that sometimes that pressure was not necessarily overt, and that they “would have carried their pregnancies to term if they had had more support.” 10/15/25 PM Tr. at 22:22–23:15 (Wubbenhorst). Based on the Coleman study, Dr. Wubbenhorst opined that “women have strong feelings postabortion that can be associated with regret” and that “it’s important to understand those existential outcomes of abortion.” 10/15/25 PM Tr. at 22:22–23:15 (Wubbenhorst).

32. Plaintiffs agree that abortion can often cause adverse mental-health outcomes. Dr. Nauser personally “grieved” her own abortions, 9/26/25 PM Tr. at 40:1–21 (Nauser), and she testified that she was aware of women becoming depressed due to an abortion, having experienced it herself, Nauser Dep. 139:18–22. Dr. Nauser has had patients tell her they are “sad,” “scared,” or “upset” about getting an abortion. Nauser Dep. 121:2–122:22.

33. At deposition, Dr. Nauser recalled the grief she felt after her own abortions. Nauser Dep. 140:9–155:18. After she became pregnant with quadruplets, she aborted two of the unborn children to ensure a more successful pregnancy for the remaining two children. Nauser Dep. 140:9–155:18. But at 20 weeks gestation, Dr. Nauser lost the two remaining children to a medical emergency. Nauser Dep. 140:9–155:18. One of them died in her arms. Nauser Dep. 140:9–155:18. Dr. Nauser remarked, “Medically, to me, they’re fetuses. To me, as Traci Nauser, as the person that was pregnant, they were babies. They had names. Jordan was a girl; Drew was the boy.” Nauser Dep. 140:9–155:18. Every Christmas, Dr. Nauser puts up “specific ornaments for them.” Nauser Dep. 140:9–155:18. Given her medical experience, Dr. Nauser was “glad ... that [she] had all the information that [she] did before [she] made that [abortion] decision.” Nauser Dep. 164:20–24.

34. There are substantial risks that women seeking abortions may be driven by coercion from third parties. Dr. Nauser has heard the following from her patients: “the relationship with the father is not very good”; “raising a child would derail their career or education”; “they don’t have the emotional capacity to do it”; and “they are getting external pressure from another family member, a mom or dad.” 9/26/25 PM Tr. at 26:18–27:19 (Nauser). And Dr. Nauser still “screen[s] for coercion in those situations” because “[t]hat is the standard of care.” 9/26/25 PM Tr. at 27:20–28:1 (Nauser). Dr. Nauser has seen patients who were being coerced, including “a minor patient and her parents [who] were trying to make her have an abortion against her will.” Nauser Dep. 170:3–23. Dr. Nauser has seen situations where the patient is “getting pressure from outside and they’re unsure.” Nauser Dep. 127:13–19.

35. Dr. Nauser testified that she has never had a patient tell her she regretted her abortion. 9/26/25 AM Tr. at 128:15–18 (Nauser). But as many as 10,000 Hodes & Nauser abortion patients “in the last 27 years” did not “even

schedule a followup” appointment. 9/26/25 AM Tr. at 130:6–12 (Nauser). “And even when abortion patients do schedule a followup, it’s frequent that they don’t show up for it.” 9/26/25 AM Tr. at 130:13–15 (Nauser); Nauser Dep. 71:1–74:1. For those patients who did not schedule or show up for a follow-up appointment, Dr. Nauser does not “know whether they regret their abortions.” 9/26/25 AM Tr. at 130:25–131:3 (Nauser).

**C. Abortion is fiercely debated in medical ethics.**

36. The Court finds that abortion is one of the most contentious medical interventions in the field of medical ethics. The parties each presented the testimony of an expert on medical ethics—Dr. Matthew Wynia for Plaintiffs and Dr. Farr Curlin for Defendants. The Court finds Dr. Curlin’s testimony more persuasive and finds that, in many important respects, Dr. Wynia’s testimony reinforced Dr. Curlin’s.

37. Plaintiffs offered the expert testimony of Dr. Matthew Wynia, a professor of bioethics at University of Colorado, who testified that the WRTKA violates all four principles of medical ethics. 10/14/25 AM Tr. at 94:7–10, 131:22–133:9 (Wynia). He acknowledged that both medical ethics and informed consent “are part of the standard of care,” 10/14/25 PM Tr. at 6:5–7, 7:4–6 (Wynia), and that, while states often follow a national standard of care promulgated by professional organizations, they can and do instead adopt state-specific standards of care, as Kansas did with respect to the WRTKA. 10/14/25 PM Tr. at 7:7–10:7 (Wynia). Dr. Wynia also acknowledged the room for difference of opinion on these questions—for example, “when there is that tension between autonomy and beneficence, different policymakers might come to different conclusions about how to resolve those competing tensions in a given context.” 10/14/25 PM Tr. at 11:7–15 (Wynia).

38. Dr. Curlin is an internist and expert in medical ethics. Dr. Wynia knows him well and “respects his thinking.” 10/14/25 PM Tr. at 23:12–14 (Wynia).

Dr. Curlin serves on the faculty of Duke Medical School as well as in Duke's Trent Center for Bioethics. 10/16/25 PM Tr. at 10:25–11:13 (Curlin). Dr. Curlin earned a medical degree from the University of North Carolina School of Medicine. 10/16/25 PM Tr. at 9:17–10:4 (Curlin); DX116 at 1. He then completed a residency in internal medicine at the University of Chicago and a fellowship in health-services research. 10/16/25 PM Tr. at 9:17–10:4 (Curlin); DX116 at 1. Upon joining the faculty at the University of Chicago, he completed another fellowship in clinical medical ethics. 10/16/25 PM Tr. at 9:17–10:4 (Curlin). Dr. Curlin also developed a “program of research at the intersection of medicine and ethics and religion, which included both empirical studies of physicians’ opinions regarding, and practices related to, a number of controversial clinical practices.” 10/16/25 PM Tr. at 10:9–24 (Curlin). For most of his time at the University of Chicago, Dr. Curlin was also on the faculty of the MacLean Center for Clinical Medical Ethics, through which he conducted “clinical ethics consultations” and “met weekly [with other faculty members] to evaluate clinical ethics cases.” 10/16/25 PM Tr. at 10:9–24 (Curlin). Dr. Curlin has won multiple awards in medical ethics. 10/16/25 PM Tr. at 12:14–24 (Curlin); DX116 at 2. He is now a professor at Duke University, where he holds a number of appointments. DX116 at 1; 10/16/25 PM Tr. at 10:25–11:10 (Curlin). Dr. Curlin is qualified to opine about the ethical dimensions of abortion based on his education, training, and experience. 10/16/25 PM Tr. at 12:25–13:6 (Curlin); *see* DX116 at 2–3; 10/16/25 PM Tr. at 13:7–15 (Curlin); *see* DX116 at 12–21.

39. Dr. Curlin’s empirical research has found that obstetrician-gynecologists “are divided about abortion” and that only 14 percent of them had ever practiced abortion. 10/16/25 PM Tr. at 13:15–14:1 (Curlin). He testified that “[m]any [OB/GYNs] support abortion in different clinical cases. And the amount of support varies depending on the clinical case. But in a typical case of elective abortion when a young woman at six or eight weeks of gestation after failed

contraception seeks abortion, 41 percent of OB/GYNs reported moral objections to abortion.” 10/16/25 PM Tr. at 13:15–14:1 (Curlin). Dr. Curlin’s coauthors for this empirical research held disparate views regarding the ethics of abortion—some viewed it as ethical in certain circumstances while others viewed it as unethical and inconsistent with medical ethics. 10/16/25 PM Tr. at 14:2–15 (Curlin). Dr. Curlin chose co-investigators with differing perspectives so that “anybody” could review his papers and regard them as reliable. 10/16/25 PM Tr. at 14:2–15 (Curlin).

40. Dr. Curlin’s testimony showed that many ethical issues attend the provision of abortion. Abortion “historically ... has been consistently opposed by the medical profession.” 10/16/25 PM Tr. at 17:22–18:23 (Curlin). From the time of the Hippocratic reform movement of ancient Greece “through the middle of the twentieth century,” no “prominent physicians or medical associations ever mention[ed] abortion without condemning it.” 10/16/25 PM Tr. at 17:22–18:23 (Curlin). After World War II, the World Medical Association gathered “physicians from all over the world ... to recover medicine’s historic commitment to important ethical principles.” 10/16/25 PM Tr. at 17:22–18:23 (Curlin). That gathering produced the Declaration of Geneva, which included a promise that “I would maintain upmost respect for human life from the time of conception, even under duress.” 10/16/25 PM Tr. at 17:22–18:23 (Curlin).

41. Abortion is a “particularly grave” decision because it is “the only intervention that sets out to intentionally kill another human being without that human being’s consent.” 10/16/25 PM Tr. at 81:6–20 (Curlin). In every context other than elective abortion, “physicians uniformly show high regard for and seek to protect the health and life of fetuses.” 10/16/25 PM Tr. at 20:8–13 (Curlin). Historically, “even as the profession uniformly opposed abortion, it has always ... held ... that physicians are obligated to do what is necessary to preserve a woman’s life and health, even if that involves effectively emptying the uterus” in what

“otherwise looks like an abortion.” 10/16/25 PM Tr. at 22:25–23:16 (Curlin). This practice is “justified” because physicians have the “primary obligation” to “do what [they] can to preserve and restore” the “woman’s life and health” and because “practically ..., in most such cases the fetus is going to die as a result of the woman’s life and health not being preserved.” 10/16/25 PM Tr. at 22:25–23:16 (Curlin). Physicians thus “preserve one life when both cannot be preserved.” 10/16/25 PM Tr. at 22:25–23:16 (Curlin).

42. Bioethicists have “deep disagreements” about the “moral status of human fetuses” and “the ethics of abortion.” 10/16/25 PM Tr. at 28:23–29:3 (Curlin). The influential textbook *Principles of Biomedical Ethics* by Beauchamp and Childress divided them into three groups. 10/16/25 PM Tr. at 29:4–19 (Curlin). Some, like Dr. Curlin, “believe that the fetus by being a human organism deserves the basic respect that we accord to all other human organisms, human beings, which is the protection from being intentionally killed.” 10/16/25 PM Tr. at 29:4–19 (Curlin). Others “don’t give the fetus full moral regard” but “give it partial regard” which “grow[s] as gestation goes on.” 10/16/25 PM Tr. at 29:4–19 (Curlin). And still others believe that “the fetus does not deserve any moral regard at all.” 10/16/25 PM Tr. at 29:4–19 (Curlin).

43. Plaintiffs do not adhere to any of these perspectives. Plaintiffs instead consider the ethics of abortion to turn on the perspective of the pregnant woman. For example, if she considers her fetus to be a human organism, Dr. Nauser will use consonant language with the woman, but if she considers her fetus to not be a human organism, Dr. Nauser will do the same. *See* Nauser Dep. 161:13–24.

44. Traditional medical ethics emphasizes “four principles,” but ethicists have tended “in recent years to emphasize autonomy to such an extent that it effectively becomes the only principle.” 10/17/25 AM Tr. at 44:21–45:15 (Curlin). So instead of considering beneficence (what is generally good) or nonmaleficence (what

is generally harmful), “conventional medical ethics” determines “whether something is good and beneficial or bad and harmful” based on “whether it is wanted or not.” 10/17/25 AM Tr. at 44:21–45:15 (Curlin). Dr. Curlin testified that “what a person wants or does not want” is an “arbitrary criterion” for deciding whether “to kill a fetus.” 10/16/25 PM Tr. at 20:14–21:2 (Curlin). This “consumerist view of medical care” sees medicine “not as a moral art, or even [oriented] to something real like the patient’s health that is genuinely good,” but as “the socially sanctioned provision of so-called healthcare services to be put to use however the person authorized to choose them wants.” 10/16/25 PM Tr. at 46:19–47:7 (Curlin).

45. Dr. Curlin testified that there is a structural “conflict of interest between patients and abortion providers.” 10/16/25 PM Tr. at 41:10–42:25 (Curlin). “[E]thically speaking, the interest[s] of abortion providers are not well aligned with the interests of women considering abortion.” 10/16/25 PM Tr. at 41:10–42:25 (Curlin). “Practically, abortion providers ... have an interest in ... providing the abortions that they believe are good and beneficial and not ethically problematic. Otherwise, they wouldn’t offer them.” 10/16/25 PM Tr. at 41:10–42:25 (Curlin). “But women who are considering abortion are often deeply conflicted about whether abortion is the right decision for them.” 10/16/25 PM Tr. at 41:10–42:25 (Curlin). Women “have an interest in making sure that their health is preserved.” 10/16/25 PM Tr. at 41:10–42:25 (Curlin). And women “have interests in making sure that they don’t consent to an intervention without really knowing what that intervention does, what the alternatives to it are, what risks and benefits attend those alternatives, and so on.” 10/16/25 PM Tr. at 41:10–42:25 (Curlin). Women also have “interests in having their own voluntariness protected and measures being taken to ensure that they are not being pushed into an abortion.” 10/16/25 PM Tr. at 41:10–42:25 (Curlin). If the WRTKA were struck down, the “harms will fall on women, not on abortion providers.” 10/16/25 PM Tr. at 41:10–42:25 (Curlin).

**V. Informed consent.**

**A. Medical and legal principles of informed consent.**

46. On medical and legal principles and application of informed consent, Defendants offered the testimony of Dr. Wubbenhorst and Dr. Curlin, and Plaintiffs offered the expert testimony of Dr. Wynia and Nadia Sawicki, a law professor at Loyola University, Chicago. 9/29/25 PM Tr. at 47:3–11 (Sawicki). The Court finds that Defendants’ expert testimony on this matter was more persuasive than the testimony of Plaintiffs’ experts. In addition, while Prof. Sawicki broadly opined that the WRTKA is inconsistent with the common law of informed consent, a matter that constitutes legal opinion within this Court’s prerogative, the Court finds that her testimony ultimately supported the disclosures in the WRTKA.

47. Informed consent “is a principle and practice within the clinical field of medicine that holds that before a physician intervenes on a patient, the physician is obligated to ensure that the patient has received sufficient information to understand what it is to which the patient might give consent, that the patient has demonstrated accurate understanding of that information, and that the patient is not under undue pressure externally or internally so that the physician has good reason to believe the patient is voluntary in consenting to that intervention.” 10/16/25 PM Tr. at 17:21–18:6 (Curlin). The parties’ experts agree that before performing a procedure, physicians must adequately disclose risks, benefits, and alternatives of the procedure and obtain informed consent from the patient. 9/29/25 PM Tr. at 81:15–82:15 (Sawicki); 10/16/25 PM Tr. at 17:19–18:14 (Curlin). “[I]n the informed consent process, the patient must understand what the procedure is;” its “risks, benefits[,] and purported outcomes;” its “short[-] and long-term effects;” and the “alternatives to the procedure.” 10/15/25 PM Tr. at 7:10–22 (Wubbenhorst). Today, “[n]o State allows medical treatment without informed consent.” 9/29/25 PM Tr. at 83:25–85:8 (Sawicki). Letting the patient ask questions is also a requirement

of informed consent, 10/15/25 PM Tr. at 7:23–25 (Wubbenhorst), as is advising a patient that foregoing the intervention is always an option, 10/16/25 PM Tr. at 18:15–21 (Curlin).

48. Informed consent is a component of the standard of care, which is ordinarily a matter of common law. Yet, as Prof. Sawicki testified, “the legislature can alter the [common] law by enacting legislation.” 9/29/25 PM Tr. at 80:2–81:7 (Sawicki); *accord* 10/14/25 PM Tr. at 7:7–10:7 (Wynia). Prof. Sawicki agreed that the “legislature can impose a duty on someone that the common law did not” and “create protections for consumers that did not exist in . . . common law.” 9/29/25 PM Tr. at 80:2–81:7 (Sawicki). The “State can legislate the standard of care” because “it is not limited by the common law of informed consent when it regulates the practice of medicine.” 9/29/25 PM Tr. at 80:2–81:7 (Sawicki). As States “abrogate the common law” and “codif[y] informed consent law into legislation,” that codified “standard controls over the common law standard that previously existed.” 9/29/25 PM Tr. at 80:2–81:7 (Sawicki). And to the extent that medical ethics govern informed consent, they do so as part of the state standard of care. 10/14/25 PM Tr. at 6:8–10:7 (Wynia).

49. The parties’ experts also agree that informed consent requires disclosure of information that is relevant to the procedure in general, not just relevant to the individual patient. 9/29/25 PM Tr. at 83:25–85:8 (Sawicki); 10/15/25 PM Tr. at 10:1–8, 12:4–14 (Wubbenhorst). As Prof. Sawicki testified, “[n]o state defines the scope of disclosures based on what the individual patient would find material.” 9/29/25 PM Tr. at 83:25–85:8 (Sawicki). Dr. Wubbenhorst opined that a patient is not harmed by being provided information that turns out to be not relevant to her specifically. 10/15/25 PM Tr. at 12:15–22 (Wubbenhorst).

50. Dr. Wubbenhorst is well qualified to opine on the application of informed-consent principles to abortion. 10/15/25 PM Tr. at 6:1–7 (Wubbenhorst);

DX117 at 2. She has performed procedures that are similar to abortion in that they ultimately resulted in the death of the fetus, but not with intent to end the fetus's life. 10/15/25 AM Tr. at 98:12–24 (Wubbenhorst). Dr. Wubbenhorst distinguishes performing a procedure to cause the death of an embryo or fetus, which she deems “intentional feticide,” from performing a procedure to save the life of the mother and the life of the unborn child if possible, which she calls a “termination of pregnancy.” 10/15/25 AM Tr. at 98:12–24 (Wubbenhorst). For example, in the first trimester she has performed dilation and curettage (D&C) procedures, and in the second trimester she has performed dilation and evacuation (D&E) procedures, which involve dilating the cervix and using instruments to remove the fetus. 10/15/25 AM Tr. at 97:21–98:11 (Wubbenhorst). She has also induced labor in the late second trimester and early third trimester to preserve the life or health of the mother. 10/15/25 AM Tr. at 97:21–98:11 (Wubbenhorst). The risks of the procedures Dr. Wubbenhorst has performed are similar to those of abortion. 10/15/25 AM Tr. at 98:25–99:22 (Wubbenhorst).

51. Dr. Wubbenhorst has also treated numerous patients experiencing complications from abortion. 10/15/25 PM Tr. at 92:5–8, 95:7–17 (Wubbenhorst). She has treated many more complications from first-trimester abortions compared to second-trimester abortions because the “vast majority of abortions [are] done in the first trimester.” 10/15/25 PM Tr. at 130:21–132:5 (Wubbenhorst). In just the year and a half before her trial testimony, she cared for “four or five women with first trimester abortion complications.” 10/15/25 PM Tr. at 132:18–133:4 (Wubbenhorst).

52. In addition, as a practicing OB/GYN, Dr. Wubbenhorst has “obtain[ed] informed consent from probably thousands of patients across the 35 years of [her] career.” 10/15/25 PM Tr. at 5:12–23 (Wubbenhorst); 10/15/25 AM Tr. at 93:15–94:5 (Wubbenhorst). She has spent significant time serving at various hospitals and

clinics nationally and internationally, and she has particular expertise with women in vulnerable and underserved populations. 10/15/25 AM Tr. at 94:6–16 (Wubbenhorst); DX117 at 2–3, 10–11. Dr. Wubbenhorst has worked in inner-city settings, Native American reservations, rural areas like Appalachia, and internationally in Cameroon, Liberia, South Sudan, Kenya, India, Nepal, and the Philippines. 10/15/25 AM Tr. at 95:5–21 (Wubbenhorst).

53. Dr. Wubbenhorst opined that the information provided in the informed-consent process “should be very detailed.” 10/15/25 PM Tr. at 10:25–11:11 (Wubbenhorst). Patient “education materials are incredibly helpful.” 10/15/25 PM Tr. at 10:25–11:11 (Wubbenhorst). She testified, “sometimes patients will download materials themselves and bring them to me and say ... this is what the article on the Internet says, what do you think.” 10/15/25 PM Tr. at 10:25–11:11 (Wubbenhorst). In her opinion, “the more information the better.” 10/15/25 PM Tr. at 10:25–11:11 (Wubbenhorst); *accord* 10/15/25 AM Tr. at 46:19–47:5 (Cole) (“[T]he more information the better.”); 10/15/25 AM Tr. at 82:17–22 (Pond) (“[M]ore information is better.”). And for elective outpatient procedures involving fertility, the informed-consent process “could occur over a period of months” for some patients. 10/15/25 PM Tr. at 11:12–12:3 (Wubbenhorst).

54. Unique concerns apply to informed consent in obstetrics and gynecology. “[B]ecause ... we deal with intimate situations such as fertility, pelvic pain[,] and, of course, coercion and abuse,” it is “extremely important” to be sensitive to these issues. 10/15/25 PM Tr. at 12:23–13:13 (Wubbenhorst). In addition, OB/GYNs must consider that they have two patients when they treat a pregnant mother—a “mom and her baby.” 10/15/25 PM Tr. at 12:23–13:13 (Wubbenhorst). And finally, OB/GYNs must consider the issue of fertility—“the [woman]’s future ability to have children.” 10/15/25 PM Tr. at 12:23–13:13 (Wubbenhorst).

55. Other unique concerns apply to informed consent in the abortion context. First, the abortion will result in “the death ... of an unborn child.” 10/15/25 PM Tr. at 13:12–25 (Wubbenhorst). And second, both the short- and long-term risks of abortion must be communicated to the patient. 10/15/25 PM Tr. at 13:14–14:2 (Wubbenhorst). Screening the patient for duress or coercion is also essential to informed consent because “where there is coercion or duress, it cannot be stated that adequate informed consent has been generated.” 10/15/25 PM Tr. at 8:1–17 (Wubbenhorst). ACOG recommends “[r]outinely screen[ing] women and adolescent girls for reproductive and sexual coercion in a safe and supportive environment that respects confidentiality.” 10/15/25 PM Tr. at 108:23–109:17 (Wubbenhorst); PX205 at 4. This is critical even if it involves asking uncomfortable questions, which in Dr. Wubbenhorst’s practice has led to the discovery of illegal conduct by a teacher in impregnating a minor. 10/15/25 PM Tr. at 8:25–9:25 (Wubbenhorst).

56. Coercion is a “very significant[]” factor in informed consent for abortion. 10/15/25 PM Tr. at 14:3–14 (Wubbenhorst). Dr. Wynia testified that he did not “know that we have any evidence that coercion and abuse are, you know, prevalent” in the context of abortion, 10/14/25 AM Tr. at 133:10–17 (Wynia), though he agreed it is “[v]ery possible” that, “in that abortion context, you might see threats to autonomy where a family member or partner is pressuring the person to get an abortion.” 10/14/25 PM Tr. at 16:17–20 (Wynia). But in fact, as Dr. Wubbenhorst explained, “research has show[n] that many abortions [are] coerced” and “that women undergoing abortion may not feel that the abortion is consistent with their own values or their own desires.” 10/15/25 PM Tr. at 14:3–14 (Wubbenhorst). One study by Dr. Susan Glander and others published in the Green Journal reported that about 3.4 percent of women in the United States are subject to domestic violence or abuse and 40 percent of women seeking abortion were in such situations. 10/15/25 PM Tr. at 69:4–12, 69:18–70:6 (Wubbenhorst); DX169 at 1002.

57. Heightened informed-consent standards apply for irreversible procedures in the field, which are common in the OB/GYN context and others, including medical aid in dying. 10/15/25 PM Tr. at 14:24–15:2 (Wubbenhorst); 10/16/25 PM Tr. at 31:3–32:3 (Curlin). As Dr. Wynia explained, “waiting periods have sometimes been imposed with the intention of promoting autonomy,” 10/14/25 PM Tr. at 18:24–19:5 (Wynia), and “it is a good intention to try and avoid people making a decision that is irreversible and which they will later . . . regret.” 10/14/25 PM Tr. at 19:6–24 (Wynia). Thus, the federal government “imposes a 30-day waiting period for sterilization procedures” that “the patient needs to understand . . . are irreversible.” 10/14/25 PM Tr. at 19:25–20:10 (Wynia); DX064. Likewise, some states, including Kansas, require specific disclosures for irreversible procedures other than abortion, including hysterectomy and tubal ligation. 10/15/25 PM Tr. at 14:24–15:20 (Wubbenhorst). Kansas requires that Medicaid patients “confirm that they understand that this is an irreversible procedure that will result in a permanent loss of fertility” on a form signed by the patient and the physician. 10/15/25 PM Tr. at 15:3–20 (Wubbenhorst). For tubal ligations, there is also a 30-day mandatory waiting period “between the time that woman signs the consent [form] and the time the tubal ligation can be performed,” with significant penalties for violation. 10/15/25 PM Tr. at 15:3–20 (Wubbenhorst); 10/16/25 PM Tr. at 32:7–22 (Curlin) (same).

58. The WRTKA “serves to protect the health of women and children by helping to [e]nsure that there is adequate informed consent generated prior to them obtaining an abortion.” 10/15/25 AM Tr. at 103:7–15 (Wubbenhorst). Dr. Wubbenhorst testified that the WRTKA “protects maternal health and safety by helping women to understand . . . that their pregnancy will result in the death of an unborn child.” 10/15/25 PM Tr. at 51:16–52:7 (Wubbenhorst). The WRTKA “gives them accurate information about the risks of abortion as well as an understanding

of the potential outcomes associated with abortion[,] including regret.” 10/15/25 PM Tr. at 51:16–52:7 (Wubbenhorst). The WRTKA upholds the integrity of the medical profession by ensuring physicians “fulfill [their] obligation as fiduciaries” by “generating appropriate informed consent” and “identifying women in situations of vulnerability, duress, coercion[,] or abuse.” 10/15/25 PM Tr. at 52:23–53:5 (Wubbenhorst). There is reliable scientific evidence that the WRTKA disclosures are “scientifically accurate and relevant.” 10/15/25 PM Tr. at 41:18–42:6 (Wubbenhorst). And the information they contain is “important for women to know” and “relevant to the procedure.” 10/15/25 PM Tr. at 42:7–16 (Wubbenhorst).

**B. Ethics of informed consent.**

59. The parties’ medical-ethics experts also testified regarding the ethical dimensions of informed consent and abortion. The Court finds the testimony of Dr. Curlin on the ethics of informed consent to be more persuasive than the testimony of Dr. Wynia.

60. State Defendants offered the expert testimony of Dr. Curlin on the ethical dimensions of informed consent. Dr. Curlin agrees that the “right of personal autonomy includes the ability to control one’s own body, to assert bodily integrity, and to exercise self-determination.” 10/17/25 AM Tr. at 39:13–24 (Curlin). The “[b]asic idea” behind the “right of bodily integrity” is that “although people do not have a right to obtain any intervention that they would like, they do have a right to refuse any medical intervention,” and physicians have a corresponding “obligation to respect their authority to refuse any medically proposed intervention.” 10/16/25 PM Tr. at 30:4–24 (Curlin). Dr. Wynia’s testimony was in accord: “[W]hat makes an autonomous decision is that you have a legitimate choice and you are able to weigh the pros and cons and risks and benefits given all aspects of the problem.” 10/14/25 PM Tr. at 15:25–16:5 (Wynia).

61. It is also “important” to “use accurate language,” particularly for “contested practices.” 10/16/25 PM Tr. at 26:12–18 (Curlin). That’s because “when physicians use euphemisms like medication abortion, that can hide features of the intervention that ... get in the way of a possibility of genuinely informed consent.” 10/16/25 PM Tr. at 26:12–18 (Curlin). They must avoid undue “medical jargon” and instead use “language that ordinary people would use” so long as that language is “clear and truthful.” 10/16/25 PM Tr. at 26:19–27:12 (Curlin).

62. Dr. Curlin opined that it is “certainly ethically justified” to have “different standards for determining whether ... consent is ... genuinely informed” for “different clinical procedures or medical interventions.” 10/16/25 PM Tr. at 31:9–32:2 (Curlin). The “more grave the decision,” the “more ... reasonable alternatives ... there are”; the “more the decision has irreversible consequences,” and the “more ... that people facing this decision might be under both internal or external pressure,” the “greater reason to require greater evidence that the patient has [genuinely] received all the information a reasonable person would want to know, has [genuinely] had an opportunity to consider that and demonstrate an understanding of it, and is genuinely making a voluntary decision.” 10/16/25 PM Tr. at 31:9–32:2 (Curlin). Dr. Wynia likewise acknowledged that more stringent informed consent requirements may apply to irreversible procedures. 10/14/25 PM Tr. at 19:6–20:7 (Wynia).

63. A policymaking body may thus “reasonably require more information” for informed consent to abortion than for other procedures because “abortion is a singular kind of intervention,” as the only intervention that involves the intentional killing of another human being. 10/16/25 PM Tr. at 36:17–37:16 (Curlin). Since “many women report that they underwent abortion in response to pressure from their partners or others,” there is “good reason to take extra pains to make sure” that the woman has “received adequate information” and “demonstrated

understanding of that information” and that her “consent is genuinely voluntary.” 10/16/25 PM Tr. at 36:17–37:16 (Curlin). It is “not uncommon[]” for the state or other institutions to require physicians to provide to patients information with which the physician may disagree. 10/16/25 PM Tr. at 44:1–21 (Curlin).

64. State-mandated informed-consent disclosures are ethically justified if they satisfy three conditions. 10/16/25 PM Tr. at 48:17–49:1 (Curlin). First, the disclosures “have a basis in medical science” and are “scientifically accurate.” 10/16/25 PM Tr. at 48:17–49:1 (Curlin). Second, the disclosures “provide information that a reasonable person would want to know in that woman’s situation.” 10/16/25 PM Tr. at 48:17–49:1 (Curlin). And third, there is “good reason to believe that without such disclosures a patient would not necessarily receive that information.” 10/16/25 PM Tr. at 48:17–49:1 (Curlin).

65. The “particularly grave” nature of the abortion decision and the fact that there are “deep conflicts among people, including among women considering abortion, about whether abortion is for them the right decision,” give “added reason” to ensure that “women have all the information [and] a chance to consider that information,” that they “are not under coercive pressure,” and that “their consent is genuinely voluntary.” 10/16/25 PM Tr. at 81:6–20 (Curlin). Here, the WRTKA “advance[s] an ethical interest in ensuring a woman’s right to self-determination and informed decision-making regarding abortion and childbirth,” as well as “an ethical interest in protecting fetal life,” and “oversight of abortion providers in the medical system.” 10/16/25 PM Tr. at 49:19–50:5 (Curlin).

66. The parties’ experts agree that waiting periods can promote autonomy. 10/14/25 PM Tr. at 18:24–19:5 (Wynia). Dr. Curlin opined that “if one has good reason to believe that this is a difficult decision for many people facing it, that there are other reasonable options, [and] that a person could be under pressure,” a waiting period “serve[s] the purpose of informed consent” to ensure the person has

“had a chance to consider that information and make his or her own decision with all the information.” 10/16/25 PM Tr. at 33:4–15 (Curlin).

67. Dr. Wynia’s testimony failed to address the central reason abortion is ethically contested: that abortion ends the life of an innocent human being. An “absolutely fundamental ... obligation” of medical ethicists when they consider a disputed question is “to address ... the key arguments contrary to” their position. 10/17/25 AM Tr. at 49:5–23 (Curlin). Dr. Wynia is “aware of the reasons why abortion has been ethically controversial,” yet he never “address[ed] the question of what regard we owe to the fetus.” 10/16/25 PM Tr. at 36:4–16 (Curlin); 10/17/25 AM Tr. at 49:5–23 (Curlin). It is not possible to “consider the ethics of an informed consent regime” for abortion “without giving substantial weight to the interests of the unborn child, fetus or embryo.” 10/16/25 PM Tr. at 35:1–16 (Curlin). The “fetus is going to suffer its death as a result of abortion,” so “you cannot consider the ethics of the action of abortion without considering what it does to the fetus.” 10/16/25 PM Tr. at 35:1–16 (Curlin). The Court agrees that Dr. Wynia did not give “due regard to the interest in fetal life in his opinions in this case.” 10/16/25 PM Tr. at 35:25–36:6 (Curlin).

68. Whether women are certain that they want an abortion when they arrive at a clinic is “irrelevant to the question of informed consent.” 10/16/25 PM Tr. at 37:17–38:10 (Curlin). “[F]requently in the practice of medicine ... people come certain of what they want precisely because they don’t yet know all the information.” 10/16/25 PM Tr. at 37:17–38:10 (Curlin). After being given all the information, “frequently people will be less certain about what ... they want to do ... because they have information about why this is the kind of decision that people struggle with.” 10/16/25 PM Tr. at 37:17–38:10 (Curlin). So “certainty is not a measure of whether someone is able to give informed consent.” 10/16/25 PM Tr. at 37:17–38:10 (Curlin).

69. Women’s autonomy is “enhanced” by receiving information not just from the perspective of abortion providers, but also from other ethical perspectives. 10/16/25 PM Tr. at 47:8–48:3 (Curlin). “[W]hen a medical ethicist or a clinician gives their opinion about what ought to be done, ... that enhances the possibility of autonomy, because it gives the patient more information.” 10/16/25 PM Tr. at 47:8–48:3 (Curlin). In the context of a controversial practice like abortion, to hear only from people who support it or only from people who oppose it “means you are only hearing one half of the story and you’re likely getting an incomplete picture of what’s at stake.” 10/16/25 PM Tr. at 47:8–48:3 (Curlin). A woman’s consent is “less informed” when she has an incomplete picture. 10/16/25 PM Tr. at 47:8–48:3 (Curlin).

70. Dr. Wynia testified that physicians should not express judgment about a patient’s choice to pursue a given medical intervention. 10/14/25 AM Tr. at 117:18–118:19 (Wynia). But the notion that physicians have an ethical obligation to avoid expressing judgment about a patient’s choice and to give “judgment free advice” is “self-contradictory,” and “not a standard that Dr. Wynia would actually follow in many cases.” 10/16/25 PM Tr. at 45:20–46:15 (Curlin). The term “judgment free advice” is an oxymoron: “You cannot give advice until and unless you make a judgment about what you should advise.” 10/16/25 PM Tr. at 45:20–46:15 (Curlin). Avoiding judgment is “not a standard that is ever applied ... across medicine or medical ethics.” 10/16/25 PM Tr. at 45:20–46:15 (Curlin). The truth of what is occurring in an abortion matters because, as Dr. Wynia acknowledges, the duty of beneficence may require a physician not to “provide the treatment that the patient is seeking,” such as where a patient “comes in and wants to have their arm taken off because they don’t feel it belongs to them and it should be removed.” 10/14/25 PM Tr. at 24:23–25:9 (Wynia).

71. The WRTKA does not “require[] a physician to indicate that he or she agrees with the information provided.” 10/16/25 PM Tr. at 44:1–21 (Curlin). The WRTKA and H.B. 2749 do “not require the physician to act as [an] agent of the state” but rather “condition how the physician will offer abortion.” 10/16/25 PM Tr. at 44:1–21 (Curlin).

**C. Kansas women lacked informed consent before the WRTKA.**

72. The only testimony of third-party witnesses who received abortions was proffered by State Defendants. Defendants proffered the testimony of Melissa Cole, Sheryl Hoyle, and Donna Pond, each of whom lived in Kansas when they obtained abortions before the WRTKA went into effect. They testified that, without the protections of the Act, they were not adequately informed about the nature of abortion and its risks and alternatives, that they wished they had received the Act’s disclosures before their abortions, and that being asked H.B. 2749’s question about the reason for their abortions is not hurtful or stigmatizing. They also testified to mistreatment by their abortion providers. The Court finds the un rebutted testimony of these women about their experience to be credible and relevant.

**1. Melissa Cole.**

73. Ms. Cole had an abortion in 1974 at the age of 15, when she lived in Overland Park, Kansas. 10/15/25 AM Tr. at 7:8–15 (Cole). When she told her mom, who was a “single mom” and “always just really busy, really stressed out,” that she was pregnant, her mom said, “You are going to have an abortion and I am going to take care of everything.” 10/15/25 AM Tr. at 8:15–9:4 (Cole). At the time, Ms. Cole did not know what an abortion was. 10/15/25 AM Tr. at 9:17–18 (Cole). Leading up to the abortion, Ms. Cole “didn’t want to think about it,” so she just “blanked it out.” 10/15/25 AM Tr. at 10:3–5 (Cole). She estimates that she was at least three or four months along. 10/15/25 AM Tr. at 9:19–10:2 (Cole).

74. The abortion occurred at a doctor's office in Kansas City, Missouri. 10/15/25 AM Tr. at 10:6–16 (Cole). Ms. Cole “had never had a gynecological exam, so [she] had never seen stirrups before.” 10/15/25 AM Tr. at 10:17–11:16 (Cole). A nurse put Ms. Cole on the table and put her feet in the stirrups. 10/15/25 AM Tr. at 10:17–11:16 (Cole). As this was happening, the nurse “didn’t talk to [her] at all.” 10/15/25 AM Tr. at 10:17–11:16 (Cole).

75. The nurse gave Ms. Cole an intravenous injection to put her to sleep. 10/15/25 AM Tr. at 10:17–11:16 (Cole). As Ms. Cole was putting her feet in the stirrups and starting to fall asleep, “the doctor came in and didn’t say anything.” 10/15/25 AM Tr. at 10:17–11:16 (Cole). “No one ... said anything to” her. 10/15/25 AM Tr. at 10:17–11:16 (Cole). She had “put ... together” that the abortion was related to her pregnancy, but in her “very immature mind,” she was “just in denial” and “didn’t want to think about it.” 10/15/25 AM Tr. at 11:21–25 (Cole).

76. Ms. Cole was not told what to expect during the abortion, and she did not receive any written materials about abortion. 10/15/25 AM Tr. at 12:1–5 (Cole). No one told her about abortion risks or alternatives, and no one gave her a description of the procedure she would undergo. 10/15/25 AM Tr. at 12:6–11 (Cole). No one asked Ms. Cole if she was sure about her decision to have an abortion, and she did not feel like she had a choice. 10/15/25 AM Tr. at 12:12–17 (Cole). Rather, she felt forced by her mother to have the abortion. 10/15/25 AM Tr. at 12:18–21 (Cole). Her mom told her, “You are going to do this, otherwise you are not going to live at our house anymore.” 10/15/25 AM Tr. at 12:22–13:2 (Cole).

77. After Ms. Cole woke up from the abortion procedure, she was “really groggy,” so the nurse helped her off the table. 10/15/25 AM Tr. at 13:9–20 (Cole). She “didn’t really understand why” she had pads on “until [she] started walking” and “could feel blood coming out.” 10/15/25 AM Tr. at 13:9–20 (Cole). The nurse took Ms. Cole back to the first room, where she changed into regular clothes and waited

30 or 45 minutes before going home. 10/15/25 AM Tr. at 13:9–20 (Cole). At home, Ms. Cole was “very sad” and “in a lot of pain.” 10/15/25 AM Tr. at 14:7–10 (Cole).

78. Ms. Cole wishes the nurse at the doctor’s office would have asked her if she was ok. 10/15/25 AM Tr. at 14:17–15:1 (Cole). She testified, “[I]t was obvious that I was not okay.... I just wish she would have had empathy to ask me[, ‘Are you okay?{’}]” 10/15/25 AM Tr. at 14:17–15:1 (Cole).

79. Today, Ms. Cole feels “very sad and very regretful” about that abortion. 10/15/25 AM Tr. at 14:11–14 (Cole). At first, she “compartmentalized” it because she “didn’t want to think about what [she] had done” and she “didn’t really understand what [she] had done.” 10/15/25 AM Tr. at 15:2–11 (Cole). But when she had her first baby later in life, she testified, “I realized that I had killed a baby.... [I]t was really terrifying, and so sad.” 10/15/25 AM Tr. at 15:2–11 (Cole). She experienced depression from her abortion. 10/15/25 AM Tr. at 15:12–22 (Cole). “[M]y body was just in shock from the trauma that it had gone through, and it was trying to heal.” 10/15/25 AM Tr. at 15:12–22 (Cole).

80. Ms. Cole’s first abortion affected her decisions in later pregnancies. 10/15/25 AM Tr. at 15:23–25 (Cole). Ms. Cole married her high-school sweetheart at age 20 and “got pregnant pretty quickly.” 10/15/25 AM Tr. at 16:1–18 (Cole). Because she had other goals she wanted to pursue and “didn’t think of it as a baby,” Ms. Cole had a second abortion in Fayetteville, Arkansas, in 1981, when she was about seven weeks along. 10/15/25 AM Tr. at 16:1–23, 54:20–21 (Cole).

81. When Ms. Cole had her second abortion, she believed the baby looked like a “bunch of cells” or a “clump of cells.” 10/15/25 AM Tr. at 18:1–5 (Cole). Now, she knows that it looks like “a fully formed beginning of a baby ... it has little eyes, it has a heartbeat .... Not at all what [she] thought.” 10/15/25 AM Tr. at 18:6–11 (Cole). She knows this because, she testified, “I have ... read and I have had a baby, so I have seen an ultrasound before.” 10/15/25 AM Tr. at 18:12–14 (Cole).

82. Leading up to the second abortion, Ms. Cole “didn’t feel anything.” 10/15/25 AM Tr. at 18:15–22 (Cole). The abortion was performed at a doctor’s office “first thing in the morning.” 10/15/25 AM Tr. at 18:23–19:9 (Cole). Ms. Cole did not receive any written materials about abortion from the doctor’s office. 10/15/25 AM Tr. at 19:10–12 (Cole). They did not give her a description of the abortion procedure or tell her about abortion risks or alternatives. 10/15/25 AM Tr. at 19:13–19 (Cole). During the procedure, she “could feel everything that the doctor was doing, and it was painful.” 10/15/25 AM Tr. at 19:20–20:5 (Cole).

83. Ms. Cole was not adequately informed before her second abortion. 10/15/25 AM Tr. at 20:6–8 (Cole). She “would have liked to have heard the heartbeat” and “seen an ultrasound,” because she “didn’t even know there was a heartbeat at that point” and she “didn’t know that they even offered such a thing.” 10/15/25 AM Tr. at 20:20–21:8 (Cole). The staff “just took [her] in a room” and “didn’t give [her] any choices.” 10/15/25 AM Tr. at 20:20–21:8 (Cole). Being provided “details about the developmental characteristics of [her] baby would have helped.” 10/15/25 AM Tr. at 21:9–12 (Cole).

84. Today, Ms. Cole feels “very sad about that abortion” because, she says, “now I know that I ended the life of my baby, and a mother is supposed to protect her baby and I didn’t protect my baby.” 10/15/25 AM Tr. at 22:7–12 (Cole). Ms. Cole’s second abortion has “greatly” affected her life. 10/15/25 AM Tr. at 22:13–23 (Cole). Her abortion “led ... to the breakup of [her] marriage” within a year. 10/15/25 AM Tr. at 22:24–23:8 (Cole). She testified that when she had her first baby, “all the past came flooding in because I realized what I had done.” 10/15/25 AM Tr. at 22:13–23 (Cole).

85. Ms. Cole became pregnant again in 1984. 10/15/25 AM Tr. at 23:11–14 (Cole). She was “madly in love with the father,” but he “did not want [her] to have the baby.” 10/15/25 AM Tr. at 23:15–22 (Cole). So Ms. Cole had a third abortion, this

one at Planned Parenthood in Texas. 10/15/25 AM Tr. at 23:25–24:1, 55:8–9 (Cole). She described it as “a very awful experience.” 10/15/25 AM Tr. at 24:2–25 (Cole).

86. Ms. Cole’s third abortion was “very similar to the other experiences in that no one spoke to” her, but it was “a very large Planned Parenthood and there were a lot of women in there.” 10/15/25 AM Tr. at 24:2–25 (Cole). When she arrived in the waiting room, “there were probably 30 women sitting in there, some had their boyfriends, some had their friends, and most of them were ... quietly crying.” 10/15/25 AM Tr. at 24:2–25 (Cole). She testified that “it was kind of shocking ... to see that many people.” 10/15/25 AM Tr. at 24:2–25 (Cole).

87. After giving her a Valium, the nurse put Ms. Cole on the table and in the stirrups, and the doctor came in. 10/15/25 AM Tr. at 24:2–25:20 (Cole). The doctor did not tell her what he was about to do. 10/15/25 AM Tr. at 25:21–23 (Cole). “But this time,” it was “difficult” for him to dilate her cervix, so “it was very painful” and she “recoiled.” 10/15/25 AM Tr. at 25:1–20 (Cole). The doctor became “mad” at her and told her to stay still. 10/15/25 AM Tr. at 25:1–20 (Cole). She was “kind of shocked that he said that,” and she “just got really quiet and tried to stay still.” 10/15/25 AM Tr. at 25:1–20 (Cole). She could hear him “pick up tools” and turn on “what sounded like a vacuum cleaner.” 10/15/25 AM Tr. at 25:1–20 (Cole). He finished the abortion in about 20 to 25 minutes, got up, and left. 10/15/25 AM Tr. at 25:1–20 (Cole).

88. After the procedure, the nurse helped Ms. Cole up, put a blanket around her, and led her to another room with dozens of recliners. 10/15/25 AM Tr. at 25:24–26:17 (Cole). There were “probably 20, 25 women in that room, and they all had blankets wrapped around them.” 10/15/25 AM Tr. at 25:24–26:17 (Cole). She “assumed they had all had the procedure like [she] had.” 10/15/25 AM Tr. at 25:24–26:17 (Cole). There were no windows, the light was dim, the paint on the walls was dingy, and the chairs were old. 10/15/25 AM Tr. at 25:24–26:17 (Cole). The room

was “filled with ... women crying and moaning.” 10/15/25 AM Tr. at 25:24–26:17 (Cole). Ms. Cole testified, “[I]t was just really, really sad. And I just looked down because I didn’t want to look at anybody’s faces because ... I knew what they were feeling.” 10/15/25 AM Tr. at 25:24–26:17 (Cole).

89. Ms. Cole “felt very dehumanized” at the Planned Parenthood clinic “because no one bothered to ask [.]How are you? How are you doing? Are you feeling okay?[,]” 10/15/25 AM Tr. at 27:10–19 (Cole). Planned Parenthood didn’t give Ms. Cole a description of the abortion procedure, and they didn’t tell her about abortion risks or alternatives. 10/15/25 AM Tr. at 27:23–28:4 (Cole). They also did not give her any written materials about abortion. 10/15/25 AM Tr. at 27:20–22 (Cole).

90. Ms. Cole was not adequately informed before her third abortion. 10/15/25 AM Tr. at 28:5–7 (Cole). She “needed to see an ultrasound,” but she “wasn’t allowed” to see an ultrasound or hear the heartbeat. 10/15/25 AM Tr. at 28:22–29:4 (Cole). “They just wanted the procedure done.” 10/15/25 AM Tr. at 28:22–29:4 (Cole).

91. A few years ago, Ms. Cole sought post-abortion counseling. 10/15/25 AM Tr. at 29:12–16 (Cole). The post-abortion counseling helped Ms. Cole “because it humanized the baby.” 10/15/25 AM Tr. at 30:1–10 (Cole). She testified, “[W]e were able to have a funeral for my babies, and I was able to write letters to them, to tell them that I was sorry, and just my hopes and dreams that I would have had for their lives[.]” 10/15/25 AM Tr. at 30:1–10 (Cole).

## **2. Sheryl Hoyle.**

92. Sheryl Hoyle has lived in Kansas for nearly her entire life. 10/14/25 PM Tr. at 125:15–23 (Hoyle). She had an abortion when she was 18 years old and engaged to be married. 10/14/25 PM Tr. at 126:16–127:5 (Hoyle). When she told her fiancé she was pregnant, he stopped communicating with her. 10/14/25 PM Tr. at

127:6–16 (Hoyle). Scared to parent on her own, she decided to have an abortion. 10/14/25 PM Tr. at 126:16–17, 127:17–18 (Hoyle).

93. Ms. Hoyle’s abortion occurred at a hospital in Salina, Kansas, in 1972, when she was about two and a half months along in her pregnancy. 10/14/25 PM Tr. at 126:16–19, 127:19–128:2 (Hoyle). Ms. Hoyle and her parents “went to the doctor’s office first and ... talked to him for a little while” and then “drove directly to the hospital and checked in” for the D&C procedure. 10/14/25 PM Tr. at 127:23–24, 128:7–12 (Hoyle). At the hospital, Ms. Hoyle did not receive any written materials about abortion, any information about risks or alternatives, or a description of the procedure she was about to undergo. 10/14/25 PM Tr. at 128:13–22 (Hoyle). Nor did anyone ask her if she was sure about her decision. 10/14/25 PM Tr. at 128:23–25 (Hoyle).

94. Before the abortion, Ms. Hoyle was given a “twilight drug.” 10/14/25 PM Tr. at 129:1–5 (Hoyle). During the procedure, she “couldn’t feel anything,” but she remembers “the doctor and the nurse talking and laughing,” “music ... playing,” and a “bright light.” 10/14/25 PM Tr. at 129:1–5 (Hoyle). She could also hear a “suction machine.” 10/14/25 PM Tr. at 129:6–9 (Hoyle).

95. After the procedure, Ms. Hoyle was “taken to a room” where there were “five to six other women who had given birth.” 10/14/25 PM Tr. at 129:10–12 (Hoyle). She stayed in that room and “cried all night long” as the “babies were brought in so [their] moms could feed them.” 10/14/25 PM Tr. at 129:10–18 (Hoyle). She testified, “it broke my heart to know that that is what I was not going to be doing, was feeding a baby.” 10/14/25 PM Tr. at 129:19–21 (Hoyle).

96. Today, Ms. Hoyle regrets her abortion. 10/14/25 PM Tr. at 129:22–23 (Hoyle). She still deals with “triggers” and “anniversary reactions” at times of the year “when the baby would have been born and when the abortion happened.” 10/14/25 PM Tr. at 129:24–130:3 (Hoyle). At those times, she experiences “[a]nger,

extreme anger, crying jags,” and “a tendency to overspend.” 10/14/25 PM Tr. at 130:4–6 (Hoyle). She also is triggered when she visits the dentist, “[b]ecause when they suck saliva out of [her] mouth, it is the same sound as when the baby was sucked out.” 10/14/25 PM Tr. at 130:7–12 (Hoyle).

97. Ms. Hoyle developed destructive behaviors. She testified, “I drank a little beforehand, but I really liked to drink afterwards, and within two months I was smoking also.” 10/14/25 PM Tr. at 130:13–17 (Hoyle). The “triggers, the nightmares, the anger, the shame, the guilt, [and] the regret” she experienced were “overpowering.” 10/14/25 PM Tr. at 150:24–151:2 (Hoyle). She testified she “was lied to and wasn’t informed of things that could happen,” so she “didn’t trust people” and “didn’t connect with anybody.” 10/14/25 PM Tr. at 130:18–24 (Hoyle); *see also* 10/14/25 PM Tr. at 130:25–131:5 (Hoyle). Ms. Hoyle’s doctor also suspected that her abortion led to fertility problems. 10/14/25 PM Tr. at 131:9–16 (Hoyle).

98. Looking back, Ms. Hoyle wishes she would have continued her first pregnancy and chosen to parent her child. 10/14/25 PM Tr. at 131:17–20 (Hoyle). She said she was not adequately informed before her abortion. 10/14/25 PM Tr. at 131:21–23 (Hoyle). Ms. Hoyle wishes that she would have been told about the consequences, the potential triggers, her options, and an “organization that would help with parenting or ... adoption.” 10/14/25 PM Tr. at 131:24–132:4 (Hoyle). She also wishes the doctor would have shown her a sonogram “[b]ecause you can see the heartbeat, you can see the baby moving.” 10/14/25 PM Tr. at 132:5–10 (Hoyle).

99. Ms. Hoyle eventually obtained help through post-abortion counseling at Wichita PCC, a pregnancy care center in Wichita, Kansas. 10/14/25 PM Tr. at 132:11–133:7 (Hoyle). Ms. Hoyle now volunteers at Open Door Health Services, a pregnancy center in Hutchinson, Kansas, where she has served for 25 years. 10/14/25 PM Tr. at 133:24–134:9, 135:19–20 (Hoyle). She is a “mentor there for two

days a week,” and she also “oversee[s] their abortion recovery program.” 10/14/25 PM Tr. at 134:2–5 (Hoyle).

### **3. Donna Pond.**

100. Donna Pond had an abortion in 1986 at the age of 16. 10/15/25 AM Tr. at 68:20–69:2 (Pond). Ms. Pond was living in Winfield, Kansas, and had been dating her boyfriend for about a year when she missed a period and went to Planned Parenthood for a pregnancy test. 10/15/25 AM Tr. at 69:3–14 (Pond). When the test was positive, Planned Parenthood staff asked Ms. Pond what she wanted to do. 10/15/25 AM Tr. at 69:15–17 (Pond). Ms. Pond said that she wanted to have an abortion because she “didn’t want to be like [her] mother, who was a ... teenage mother.” 10/15/25 AM Tr. at 69:15–20 (Pond). Ms. Pond does not recall Planned Parenthood telling her about the risks of abortion or any options other than abortion. 10/15/25 AM Tr. at 69:21–23, 70:5–6 (Pond). Planned Parenthood also did not encourage her to talk to her parents about her pregnancy. 10/15/25 AM Tr. at 70:8–11 (Pond).

101. Planned Parenthood referred Ms. Pond to a clinic in Wichita for the abortion. 10/15/25 AM Tr. at 69:24–70:4 (Pond). She was five to eight weeks along. 10/15/25 AM Tr. at 70:15–17 (Pond). Before the procedure, the nurse explained to Ms. Pond that they “would be doing a D&C, scraping the uterine wall and suction.” 10/15/25 AM Tr. at 71:7–16 (Pond). She also gave Ms. Pond a Valium to keep her calm. 10/15/25 AM Tr. at 71:7–12 (Pond).

102. Ms. Pond believes the Valium “dulled [her] senses,” so she did not have “a clear sense of what was happening to [her].” 10/15/25 AM Tr. at 83:13–16 (Pond). Ms. Pond does not recall the doctor “describing what he was going to do.” 10/15/25 AM Tr. at 71:22–24 (Pond). He “perform[ed] a sonogram to locate the fetus” and discovered she was pregnant with twins. 10/15/25 AM Tr. at 71:25–72:7 (Pond). After the doctor left, Ms. Pond asked the nurse “if the Valium was harmful to the

babies, because [she] was having second thoughts and just wasn't sure what [she] was doing was right." 10/15/25 AM Tr. at 72:8–17 (Pond). The nurse "discouraged" her and told her, "[I]f you can't take care of one baby, what makes you think you can take care of two." 10/15/25 AM Tr. at 72:18–21 (Pond).

103. No one told Ms. Pond that she was capable of raising the babies or asked her if she was certain that she wanted the abortion. 10/15/25 AM Tr. at 72:22–73:2 (Pond). Nor did they tell her that she could stop the procedure at that point. 10/15/25 AM Tr. at 73:3–5 (Pond). Ms. Pond wishes someone had told her that she could stop the procedure, because she "was very unsure that [she] was doing the right thing." 10/15/25 AM Tr. at 73:16–21 (Pond).

104. The doctor then came back into the room and performed the procedure. 10/15/25 AM Tr. at 73:22–24 (Pond). Ms. Pond remembers "the sensation of the tugging, and sounds." 10/15/25 AM Tr. at 73:25–74:9 (Pond). Only about 15 to 20 minutes elapsed between the nurse's explanation of the procedure and the procedure itself. 10/15/25 AM Tr. at 83:17–20 (Pond). Only after the procedure was complete did she receive the sonogram. 10/15/25 AM Tr. at 73:25–74:21 (Pond).

105. Immediately after the abortion, Ms. Pond felt "a little indifferent, not happy about the whole situation, [and] sad." 10/15/25 AM Tr. at 74:22–25 (Pond). Knowing what she knows today, Ms. Pond wishes she "would have had more information, ... gone over options, and seen the sonogram before the procedure was done." 10/15/25 AM Tr. at 75:10–16 (Pond).

106. Today, Ms. Pond "regret[s] her decision" and wishes she "wouldn't have had an abortion." 10/15/25 AM Tr. at 75:21–24 (Pond). She has "dealt with a lot of depression, grief, regret, [and] guilt." 10/15/25 AM Tr. at 75:25–76:2 (Pond). She "always wanted to be a mother," but she never had other children. 10/15/25 AM Tr. at 74:13–14, 76:3–6 (Pond). She tries not to think about it, but she is occasionally reminded. 10/15/25 AM Tr. at 76:7–20 (Pond).

107. Ms. Pond wishes she “would have carried [the twins] to term and had the decision of whether to raise them or give them up for adoption.” 10/15/25 AM Tr. at 76:21–25 (Pond). She wishes she “would have had the opportunity to have time to think about it and ... discuss [her] options.” 10/15/25 AM Tr. at 77:7–13 (Pond). She also wishes they would have encouraged her to talk to her parents because, she testified, “If I would have talked to my mother, ... I know I wouldn’t have had the abortion. She was against them, and she would have given me the support that I needed to make either a decision of adoption or caring for them myself.” 10/15/25 AM Tr. at 77:14–23 (Pond).

## **VI. Effect of the Challenged Statutes on Plaintiffs.**

108. Plaintiffs complied with the WRTKA from the time of its enactment until the Court issued its temporary injunction, at which point they stopped complying. 9/26/25 AM Tr. at 124:1–9 (Nauser); 9/30/25 AM Tr. at 36:12–22 (Wales). While the WRTKA was in effect, Plaintiffs saw tens of thousands of women for abortions. And “there have been many thousands of patients who received an abortion that ... haven’t come back for a checkup visit.” 9/26/25 PM Tr. at 41:3–9 (Nauser).

109. In general, Plaintiffs instructed abortion patients to print WRTKA forms from their websites and bring them into their offices. *See* 10/14/25 AM Tr. at 72:14–73:8 (Huntington); 9/26/25 AM Tr. at 61:15–62:19 (Nauser); 9/30/25 AM Tr. at 38:18–39:1 (Wales). However, Plaintiffs could and did comply with the WRTKA in other ways, such as by sending the disclosures by mail. 9/29/25 AM Tr. at 17:1–3 (Alsaden). Hodes & Nauser sometimes mailed consent forms “directly to patients.” 10/14/25 AM Tr. at 27:23–28:16 (Ranney). Before the Internet, Hodes & Nauser “mailed the packets to patients.” 9/26/25 AM Tr. at 76:19–77:2 (Nauser); 9/26/25 PM Tr. at 20:17–21:11 (Nauser). Ms. Ranney ensured that “the forms that [Hodes & Nauser] sent in the mail” were “the correct forms.” 10/14/25 AM Tr. at 27:23–28:16

(Ranney). Hodes & Nauser “did not charge patients a fee” for mailing the forms. 10/14/25 AM Tr. at 27:23–28:16 (Ranney).

110. “[N]othing in the Woman’s Right to Know Act would prohibit” Hodes & Nauser from “cho[osing] again to mail or to Fed Ex the consent forms to patients instead of having patients print them out.” 9/26/25 PM Tr. at 20:17–21:11 (Nauser). Plaintiffs could offset that cost with a reservation fee. 9/26/25 PM Tr. at 19:2–20:16 (Nauser). Sending disclosures by mail would not delay abortions that would otherwise occur, since the average time to schedule an abortion is more than 24 hours. 10/16/25 AM Tr. at 6:18–21 (Sandoval). And though Comprehensive Health pays for the travel or other expenses of as many as 850 patients a month, they never paid to mail a WRTKA 24-hour consent form to a patient. 10/14/25 AM Tr. at 64:23–67:21; 68:5–10; 71:3–6 (Huntington).

111. Plaintiffs’ chosen method of compliance with the WRTKA’s 24-hour written-disclosure requirement added steps not required by the law itself. For example, Dr. Nauser testified that if there were “anything wrong with the consent forms from a visual standpoint, [she] would not be able to see [patients] because of the state law.” 9/26/25 AM Tr. at 61:15–62:19 (Nauser); *see also* 10/14/25 AM Tr. at 27:2–7 (Ranney) (blurred forms). In addition, Hodes & Nauser would speak with patients over the phone and “document the date and time that they completed reading through that consent form.” 10/14/25 AM Tr. at 12:1–10 (Ranney); 10/14/25 AM Tr. at 15:14–22 (Ranney); 10/14/25 AM Tr. at 26:4–14 (Ranney).

112. Plaintiffs produced no documents showing that the temporary injunction against the WRKTA caused any increase in their capacity to provide abortions. 9/30/25 AM Tr. at 62:2–7 (Wales). When the injunction issued, Comprehensive Health was already taking multiple steps to increase its capacity. 9/30/25 AM Tr. at 62:8–63:5 (Wales). And Dr. Nauser’s schedule “hasn’t been as full

lately” because “other facilities in Kansas are offering the same procedure.” 9/26/25 PM Tr. at 24:11–25:1 (Nauser).

113. Before the *Dobbs* decision, Plaintiffs were meeting the local need for abortion, but afterwards, Plaintiffs experienced a dramatic increase in women seeking abortions from out of state. 9/30/25 AM Tr. at 63:6–10 (Wales). Since *Dobbs*, “more of the abortion patients [Dr. Nauser sees] are from further out of state.” 9/26/25 PM Tr. at 25:2–12 (Nauser). She still sees “a lot of patients from Missouri,” 9/26/25 PM Tr. at 25:2–12 (Nauser), as well as patients from “Texas, Oklahoma, Arkansas, Nebraska, Louisiana, [and] some as far as Florida.” 9/26/25 AM Tr. at 47:1–9 (Nauser); Nauser Dep. 77:5–25, 80:1–81:18. “At least as late as April of 2023, ... all out-of-state abortions [at Hodes & Nauser] were surgical abortions.” 10/14/25 AM Tr. at 30:4–17 (Ranney). This was because “it would be difficult to follow up with out-of-state patients who had medication abortion[s].” 10/14/25 AM Tr. at 30:4–21 (Ranney). Given the out-of-state demand, if Dr. Nauser “had more providers that could provide the service, [Hodes & Nauser] could see more patients.” Nauser Dep. 290:17–291:2.

114. Comprehensive Health advertises to women who live outside of Kansas to have abortions at its Kansas clinics. 9/30/25 AM Tr. at 63:11–23 (Wales). At the time of the lawsuit, between 50% and 75% of Comprehensive Health’s patients came from outside Kansas. Deposition of Selina Sandoval, M.D., 128:8-9, 128:16-18, 128: 20-24, 129:2-3 (“Sandoval Dep.”).

115. Comprehensive Health’s corporate representative testified that it considers disclosures required by the WRTKA “the State of Kansas’ speech.” 9/30/25 AM Tr. at 68:12–22 (Wales). It further testified that the disclosures are not Comprehensive Health’s speech. 9/30/25 AM Tr. at 68:12–22 (Wales).

116. Dr. Nauser agreed that “nothing in the Woman’s Right to Know Act requires that [she] verbally say the things included in the disclosures.” 9/26/25 AM

Tr. at 125:14–17 (Nauser). In fact, she testified that “Hodes & Nauser treats the required disclosures in the ... Act as the message of the state of Kansas.” 9/26/25 AM Tr. at 125:18–21 (Nauser); Nauser Dep. 307:23–310:1. For example, when she “gave patients the KDHE booklet on fetal development, [she] would tell them this is material from KDHE that [she’s] required to give.” 9/26/25 AM Tr. at 125:22–126:1 (Nauser). The same was true for the posted signage. 9/26/25 AM Tr. at 126:4–10 (Nauser); *see also* PX112. She would “sometimes let the patient know that [she] thought that information was false.” 9/26/25 AM Tr. at 126:9–17 (Nauser). And on the consent forms that Hodes & Nauser provided, the clinic included the following disclaimer: “The State of Kansas requires us to make the following statements which we believe to be medically inappropriate, misleading, and ideologically motivated.” 9/26/25 AM Tr. at 127:9–18 (Nauser); *see also* DX041 at 578. Dr. Nauser understood that she could comply with the breast-cancer and preterm-birth disclosures by “simply stating that no such risks exists.” 9/26/25 AM Tr. at 127:19–24 (Nauser). And for the fetal-pain disclosures, she would tell patients, “[W]e disagree with this, but we’re required to tell you that.” 9/26/25 AM Tr. at 127:25–128:4 (Nauser); Nauser Dep. 307:23–310:1.

117. Plaintiffs’ providers lack a close or ongoing relationship with the women for whom they provide abortions. The physicians at Planned Parenthood’s clinics regularly change over. 9/30/25 Tr. at 31:10–14 (Wales). Most of their physicians reside outside of Kansas and provide abortion remotely, by telephone or video teleconference. 9/30/25 Tr. at 50:15–21 (Wales). *See also* 9/26/25 AM Tr. at 130:6–12 (Nauser) (stating that it is possible that she has had 10,000 abortion patients over the years who did not schedule a follow-up appointment).

118. Planned Parenthood’s patients have filed complaints about the lack of closeness and the manner in which they were treated. In one complaint, a patient described showing up for her appointment and being “treated like what I had to say

didn't matter with no additional explanation, and then was told to pay what I owed and go sit back down." 9/30/25 AM Tr. at 92:14–19 (Wales). The patient said it felt like "everyone who worked [at the clinic] was calloused and didn't care at all about patients. 9/30/25 AM Tr. at 92:20–93:2 (Wales).

119. The same patient described the clinic's process as "being herded around like cattle" or being part of a "very mechanical process." 9/30/25 AM Tr. at 93:3–12 (Wales). She complained that "everyone was rude, and no one wanted to be there." 9/30/25 AM Tr. at 90:20–23 (Wales).

120. Plaintiffs continue to comply with many provisions of the WRTKA despite the Court's temporary injunction. For example, Dr. Nauser "still offer[s] patients the opportunity to view their ultrasound" and "still give[s] patients the opportunity to meet with [her] and ask questions before they have their abortion." 9/26/25 PM Tr. at 34:22–35:11 (Nauser). And both Plaintiffs continue to provide informed-consent forms to all abortion patients, which range from 4 to 8 pages. 9/26/25 PM Tr. at 8:9–17 (Nauser); 9/26/25 AM Tr. at 61:19–25 (Nauser); 10/14/25 AM Tr. at 91:16–25 (Huntington); *see also* 9/26/25 PM Tr. at 8:18–23 (Nauser) (saying 11 and 15 pages are "not too much for [the patient] to process"). Planned Parenthood uses videos to provide patients with information for informed consent. 10/16/25 AM Tr. at 7:23–10:7 (Sandoval). Those videos discuss abortion alternatives for just four seconds. DX061 at 7:25–7:29.

## **VII. Effect of the Challenged Statutes on pregnant women.**

121. Plaintiffs failed to proffer any credible evidence that pregnant women are harmed by the WRTKA. Plaintiffs offered no testimony of any of their past, current, or future patients about the alleged harm caused by the WRTKA. No woman who has had an abortion in Kansas subject to the WRTKA testified in support of Plaintiffs' claims that the WRTKA infringes patient autonomy. And Plaintiffs did not identify a single complaint from a woman claiming that the

WRTKA “prevented her from receiving adequate care.” 9/30/25 AM Tr. at 77:3–8 (Wales). The only testimony from abortion patients—other than Dr. Nauser, who testified that it was not possible to have more information about abortion than she did, Nauser Dep. 164:24–166:20—was that they wish they had received the disclosures required by the WRTKA. Both Plaintiffs admitted that women sometimes change their mind and choose not to have an abortion after receiving the WRTKA’s disclosures. Nauser Dep. 94:21–95:17; 9/29/25 AM Tr. at 21:22–22:14 (Alsaden).

122. Complaints from Planned Parenthood’s patients show that women often receive insufficient information about abortion. One patient said that her doctor “did not prepare me for what my body was about to experience.” 9/30/25 AM Tr. at 93:13–20 (Wales). She said she was not warned about the extent of pain or bleeding she would experience and told Planned Parenthood that “this lack of information should be illegal.” 9/30/25 AM Tr. at 93:21–94:8 (Wales). When she complained, she was told she “should have expected it.” 9/30/25 AM Tr. at 94:9–14 (Wales).

123. Plaintiffs acknowledge that “it is possible that some women do want the information from the Woman’s Right to Know Act before they would make a decision about an abortion,” even “if they didn’t ask for it.” They may even “after the fact wish they had received that information.” 9/26/25 PM Tr. at 52:12–53:25 (Nauser). Dr. Nauser has not “done any systematic study of [her] patients to understand how they feel about the ... Act.” 9/26/25 PM Tr. at 54:1–4 (Nauser).

124. Lacking evidence of harm to any specific women, Plaintiffs attempted to prove general harm from the challenged laws through the expert testimony of Dr. Katrina Kimport, a sociologist, 9/30/25 PM Tr. at 5:13–16 (Kimport), and Dr. Nicholas Syrett, a historian. 10/14/25 PM Tr. at 47:19–22 (Syrett). The Court finds the testimony of Dr. Kimport and Dr. Syrett to be not credible or persuasive.

125. The Court starts with Dr. Syrett’s opinion that Kansas laws perpetuate sex stereotypes and are a form of reproductive control. This opinion is circular and standardless. He admitted that his “definition of [what] reproductive control encompasses has some gray areas,” such as laws on statutory rape or prostitution. 10/14/25 PM Tr. at 91:1–11 (Syrett). This means that reproductive control is “okay” in “certain circumstances.” 10/14/25 PM Tr. at 91:19–92:21 (Syrett). Dr. Syrett also acknowledged that waiting periods have been used to protect against “forced sterilization,” which “is a form of reproductive control,” but he did not explain why waiting periods were inappropriate here. 10/14/25 PM Tr. at 92:22–93:24 (Syrett). His opinion lacks the meaningful objective standards required for expert evidence.

126. Dr. Syrett also opined that Kansas law is infected with sex stereotypes. He didn’t “claim to know the motivations of any individual legislator in Kansas,” yet he believes that “every legislat[or] that voted for the challenge[d] laws in this case was motivated by sex stereotypes.” 10/14/25 PM Tr. at 96:6–99:3 (Syrett). That includes “all of the women that supported that law, including legislators and people that submitted committee testimony.” 10/14/25 PM Tr. at 96:6–99:3 (Syrett). Using this method, he “attribute[ed] the motivations of laws that were passed in the 1860s to people that voted on bills in the 1990s and just last year, in 2024.” 10/14/25 PM Tr. at 96:6–99:3 (Syrett). This subjective opinion is of no help to the Court in finding the key facts of this case.

127. Dr. Kimport’s testimony about H.B. 2749 has similar flaws. She did not “perform any original research for this matter” but instead found that the challenged laws cause stigma by looking at “existing literature about laws regulating abortion and abortion stigma,” none of which concerns a law like H.B. 2749. 9/30/25 PM Tr. at 5:23–7:20 (Kimport). Because H.B. 2749 “isn’t in place,” she “couldn’t quantify any effect that it had.” 9/30/25 PM Tr. at 8:10–11:15 (Kimport).

Nor could she “say how many women may feel those affects.” 9/30/25 PM Tr. at 8:10–11:15 (Kimport). She could not “tell the Court what percentage of women who were asked [H.B. 2749’s] questions would experience negative emotions.” 9/30/25 PM Tr. at 8:10–11:15 (Kimport). She could not “tell the Court how many that were asked these questions would feel increased regret for their abortion.” 9/30/25 PM Tr. at 8:10–11:15 (Kimport). Such an opinion is unmoored from existing science and unhelpful to the Court’s task as factfinder.

128. Dr. Kimport’s definition of an “abortion restriction” that causes stigma is so broad as to be meaningless. According to her, an abortion restriction is “any law that constrains access to abortion in a way that’s not medically necessary or essentially aimed at improving the safety of abortion.” 9/30/25 PM Tr. at 11:16–14:17 (Kimport). That includes laws that ban “sex selective abortion,” laws that ban “the use of public funds for covering abortions,” and even 30-week and 36-week abortion bans. 9/30/25 PM Tr. at 14:18–17:7 (Kimport).

## **VIII. Lack of proof of harm from the challenged provisions.**

### **A. The 24-hour waiting period.**

129. The 24-hour waiting period in K.S.A. 65-6709(a) does not injure patients because the harms alleged by Plaintiffs are caused by Plaintiffs’ actions, not the WRTKA.

130. None of Plaintiffs’ former patients testified or were identified to testify regarding any violation of their rights caused by the WRTKA’s 24-hour consent form. 9/30/25 AM Tr. at 44:22–45:24 (Wales). Plaintiffs did not identify any specific woman who was unable to obtain an abortion because of the 24-hour consent form. 9/30/25 AM Tr. at 41:23–42:10 (Wales); 9/30/25 AM Tr. at 17:14–20 (Wales). Nor do they have any documentary evidence of a patient who did not receive an abortion because of the 24-hour consent form. 9/30/25 AM Tr. at 42:11–16, 44:7–21 (Wales). Women who presented with 24-hour consent forms that did not meet Plaintiffs’

requirements would be rescheduled and “wouldn’t be denied the ability to obtain an abortion.” 9/26/25 PM Tr. at 129:4–6 (Alsaden).

131. Plaintiffs’ only evidence of purported patient harm from this provision was narrative evidence of unidentified patients for whom Plaintiffs produced no documents that would allow Defendants to test their claims. For example, Dr. Alsaden testified that “no fewer than 10” women a week were turned away for improper forms, but Comprehensive Health did not produce any documentation regarding a single woman who was turned away. Deposition of Iman Alsaden, M.D., 193:6–19 (“Alsaden Dep.”); 10/14/25 AM Tr. at 41:13–52:21 (Huntington). Plaintiffs proffered no evidence that any of those women were ultimately prevented from obtaining an abortion. And Hodes & Nauser referred to only a single patient who it claimed, due to incorrect forms, was unable to obtain an abortion. 10/14/25 AM Tr. at 30:22–31:9 (Ranney); PX35. Even that was speculation, since it was based solely on the inference that the woman had called to follow up to understand why she could not be seen. 10/14/25 AM Tr. at 30:22–31:9 (Ranney). It is also contrary to the documents Plaintiffs proffered—as Dr. Nauser testified, she assumed the woman could still obtain an abortion (since the clinic had quoted a price for it) and Dr. Nauser had no knowledge as to whether the woman ultimately did so. 9/26/25 AM Tr. at 15:20–16:11 (Nauser); PX35. Further, since Plaintiffs did not produce any documents related to this patient, it is impossible to know whether any purported error on the forms (not specified by Plaintiffs) was real, as opposed to one of Plaintiffs’ optional methods of compliance.

132. Even assuming that delay of abortion for some patients, without more, can constitute infringement of the right to autonomy under *Hodes*, Plaintiffs did not prove that any delay was caused by the WRTKA as opposed to their own optional methods of compliance. See 9/26/25 PM Tr. at 79:14–80:2 (Alsaden); see 10/14/25 AM Tr. at 15:14–22 (Ranney). As set forth above, the evidence showed that Plaintiffs

could have complied with the WRTKA by mailing disclosures to patients. That would not have delayed procedures, since Comprehensive Health’s patients typically schedule their appointments 1–2 weeks out. 9/29/25 AM Tr. at 16:11–15 (Alsaden); 10/16/25 AM Tr. at 6:18–21 (Sandoval). And in the unusual event that the 24-hour waiting period meant a woman could not obtain an abortion in Kansas because it would push her appointment past 22 weeks’ gestation, Comprehensive Health would refer that patient to an out-of-state clinic and “figured out how to get them” to that clinic. 9/30/25 AM Tr. at 14:18–15:6 (Wales). Notably, Plaintiffs do not challenge Kansas’s 22-week gestational limit.

133. In addition, isolated cases of delay are insufficient to facially invalidate a waiting period that promotes autonomy. Plaintiffs acknowledged that some women did change their minds about choosing an abortion after they received the WRTKA disclosures. 9/26/25 PM Tr. at 25:19–29:21 (Nauser); 9/29/25 AM Tr. at 21:22–22:14 (Alsaden). Dr. Wynia testified that waiting periods have been instituted to promote autonomy, 10/14/25 PM Tr. at 18:24–19:5 (Wynia), and Dr. Curlin testified that “waiting periods are a kind of perennial aspect of engaging with medicine,” 10/17/25 AM Tr. at 50:20–51:1 (Curlin).

134. The WRTKA’s 24-hour waiting period is “ethically justified” because “one has good reason to believe that [abortion] is a difficult decision for many people facing it, that there are other reasonable options, [and] that a person could be under pressure.” 10/16/25 PM Tr. at 33:4–22 (Curlin); *see also* 10/16/25 PM Tr. at 49:2–7 (Curlin).

135. In addition, the testimony of Kansas women who received abortions supports the waiting period. Ms. Pond wishes that she had received information about the abortion procedure and its risks, benefits, and alternatives 24 hours before her abortion. 10/15/25 AM Tr. at 84:4–8 (Pond). She “was already having second thoughts” without this information, so if she had “more time to think about

it,” she is “pretty certain” she “would have changed [her] mind.” 10/15/25 AM Tr. at 84:4–12 (Pond).

**B. Paper format.**

136. The paper-format requirement of K.S.A. 65-6709(a) does not injure patients because Plaintiffs use paper forms even when compliance with the WRTKA is not required. 9/30/25 AM Tr. at 34:10–19 (Wales); 9/26/25 AM Tr. at 62:20–63:1 (Nauser).

137. Comprehensive Health continues to use paper HIPAA forms and informed-consent forms after the WRKTA was enjoined. 10/14/25 AM Tr. at 91:16–25 (Huntington). Its employees agreed that these forms “didn’t create a barrier to care.” 10/14/25 AM Tr. at 92:1–3 (Huntington).

138. It is “ethically justified” to “require informed consent information to be given in multiple formats, for example, orally and in writing” because “medical literacy is always imperfect.” 10/16/25 PM Tr. at 34:15–25 (Curlin).

**C. Physician credentialing.**

139. Plaintiffs proffered no direct or hearsay evidence that the physician-credentialing provision of K.S.A. 65-6709(a)(1) caused any patient harm or that it requires disclosure of information without an adequate scientific basis.

140. Comprehensive Health is not aware of any harm to patients from receiving the information identified in K.S.A. 65-6709(a)(1). 9/30/25 AM Tr. at 52:1–8 (Wales). At the time of the suit, a majority of Comprehensive Health’s abortion-providing physicians were independent contractors practicing primarily outside the state of Kansas. 9/30/25 AM Tr. at 50:6–21 (Wales). Plaintiffs voluntarily collect all the information required by the WRTKA as part of their internal credentialing process to ensure providers are qualified. 9/30/25 AM Tr. at 47:23–49:22 (Wales). Dr. Nauser testified that she would be happy to answer any patient’s question about

malpractice insurance or her disciplinary history. Nauser Dep. 189:11–190:22, 191:12–192:6.

141. Plaintiffs’ expert admitted that the K.S.A. 65-6709(a)(1) disclosures “do[] not undermine the patient’s bodily autonomy.” 9/29/25 PM Tr. at 87:4–88:25 (Sawicki).

**D. Description of procedure.**

142. Plaintiffs proffered no direct or hearsay evidence that the procedure-description disclosure of K.S.A. 65-6709(a)(2) caused any patient harm or that it requires disclosure of information without an adequate scientific basis.

143. Comprehensive Health continues to provide patients with a description of the procedure. 9/29/25 AM Tr. at 12:2–5 (Alsaden). Dr. Alsaden testified that she does not object to disclosing the methods for abortion. 9/29/25 AM Tr. at 28:25–31:3 (Alsaden). And Dr. Nauser agreed that “describing the proposed abortion method is truthful” and “relevant information.” Nauser Dep. 195:6–15.

144. Plaintiffs’ expert admitted that the WRTKA’s procedure-description provision is “consistent with informed consent doctrine” and “supports the patient’s bodily autonomy when deciding whether to have an abortion.” 9/29/25 PM Tr. at 89:1–13 (Sawicki).

145. Dr. Curlin opined that the State of Kansas is ethically justified in requiring a woman to receive the WRTKA’s disclosures about the nature of abortion. 10/16/25 PM Tr. at 49:8–13 (Curlin).

**E. Disclosure of risks and alternatives.**

146. Plaintiffs proffered no direct or hearsay evidence that the disclosure of risks and alternatives required by K.S.A. 65-6709(a)(3) and (7) caused any patient harm or that it requires disclosure of information without an adequate scientific basis.

147. Comprehensive Health continues to provide a description of the risks of the procedure even while not subject to the WRTKA. 9/29/25 AM Tr. at 12:1–3 (Alsaden). Dr. Alsaden testified that she does not object to disclosing the risks of and alternatives to abortion. 9/29/25 AM Tr. at 28:25–31:3 (Alsaden). And Dr. Nauser still advises patients of risks when performing abortions. 9/26/25 PM Tr. at 30:7–34:14 (Nauser); *see also* DX043.

148. Information about risks and alternatives is relevant to abortion patients' decisions. Ms. Cole was not told about the physical or emotional risks of abortion before her abortions, but it "would have affected" her if she had. 10/15/25 AM Tr. at 35:25–36:2, 36:14–21 (Cole). Ms. Hoyle was never told about the physical or emotional risks of abortion, and she wishes she was. 10/14/25 PM Tr. at 138:5–17 (Hoyle). And Ms. Pond was not told about the physical or emotional risks before her abortion, and she wishes she had. 10/15/25 AM Tr. at 81:3–21 (Pond).

149. Dr. Curlin opined that the State of Kansas is ethically justified in requiring a woman to receive the WRTKA's disclosures about risks of abortion and alternatives to abortion. 10/16/25 PM Tr. at 49:8–13 (Curlin).

150. Plaintiffs' expert admitted that requiring a "description of risks related to the proposed abortion method" is "consistent with common law informed consent standards." 9/29/25 PM Tr. at 89:14–91:15 (Sawicki). Indeed, "not disclosing a specific risk [is] a violation of informed consent." 9/29/25 PM Tr. at 89:14–91:15 (Sawicki). She also admitted that requiring "a description of alternatives to the abortion that a reasonable patient would consider material to the decision of whether or not to undergo the abortion," is "consistent with informed consent" and adopts the accepted "reasonable patient standard for the scope of disclosure." 9/29/25 PM Tr. at 89:14–91:15 (Sawicki). Such disclosure also "support[s] a woman's bodily autonomy when deciding whether to get an abortion." 9/29/25 PM Tr. at 89:14–91:15 (Sawicki).

**F. Probable gestational age and anatomy.**

151. Plaintiffs proffered no direct or hearsay evidence that the disclosure of probable gestational age and anatomy required by K.S.A. 65-6709(a)(4) and (5) injures patients or that it requires disclosure of information without an adequate scientific basis.

152. Information about probable gestational age and fetal anatomy is relevant to abortion patients' decisions. Ms. Cole was never told the probable gestational ages of her unborn children or given information about their development. But if she had been given that information, it would have "especially" affected her first abortion. 10/15/25 AM Tr. at 38:16–39:4 (Cole). Ms. Hoyle was not given any information about how developed her unborn baby was, but she wishes she had been. 10/14/25 PM Tr. at 139:18–140:10 (Hoyle).

153. Dr. Curlin testified that the State of Kansas is ethically justified in requiring a woman to receive the WRTKA's disclosures about the nature of abortion. 10/16/25 PM Tr. at 48:8–13 (Curlin).

**G. Counseling disclosures.**

154. Plaintiffs proffered no direct or hearsay evidence that the disclosure of contact information for counseling assistance for medically challenging pregnancies, perinatal hospice services, and perinatal assistance required by K.S.A. 65-6709(a)(6) injures patients or that it requires disclosure of information without an adequate scientific basis.

155. Since the WRTKA was enjoined, Plaintiffs continue to provide patients with information about available counseling services. 9/29/25 AM Tr. at 12:6–8 (Alsaden).

**H. Anti-Rh immune disclosure.**

156. Plaintiffs proffered no direct or hearsay evidence that the disclosure of anti-Rh immune globulin therapy required by K.S.A. 65-6709(a)(8) injures patients or requires disclosure of information without an adequate scientific basis.

157. Since the WRTKA was enjoined, Hodes & Nauser still does “Rh testing on all ... patients that are having abortions.” Nauser Dep. 53:3–25.

**I. Whole, separate, unique, living human being.**

158. Plaintiffs proffered no direct or hearsay evidence that the disclosure that abortion terminates the life of a whole, separate, unique, living human being required by K.S.A. 65-6709(b)(5) injures patients or requires disclosure of information that is supported by an adequate scientific basis.

159. Plaintiffs proffered no scientific testimony showing that this disclosure is false. Dr. Nauser agreed that the unborn child is “unique.” 9/26/25 AM Tr. at 93:13–24 (Nauser). Further, she agreed “that a fetus has separate DNA from its mother.” 9/26/25 PM Tr. at 6:5–7 (Nauser).

160. Defendants presented the expert testimony of Dr. Maureen Condic that fetuses are whole, separate, unique, living human beings. She testified that they are whole because they are complete human organisms, separate because they are different individuals from their mother, unique because they have their own genetic information, and living because they have all the characteristics of life. 10/16/25 AM Tr. at 77:19–80:20 (Condic).

161. Dr. Wubbenhorst testified that the WRTKA’s disclosure that “abortion terminates the life of a whole, separate, unique, living human being” is scientifically accurate. 10/15/25 PM Tr. at 42:17–43:15 (Wubbenhorst). “It is [i]ncontrovertible that an embryo and a fetus are human beings,” according to human-embryology textbooks and Van Nostrand’s Encyclopedia. 10/15/25 PM Tr. at 42:17–43:15 (Wubbenhorst). Many textbooks and scientific authorities “state that the embryo

and fetus are human” since they have “human DNA” that is distinct from their mother’s DNA. 10/15/25 PM Tr. at 42:17–43:15 (Wubbenhorst). The embryo or fetus is “clearly alive” and “metabolizes.” 10/15/25 PM Tr. at 42:17–43:15 (Wubbenhorst). Many textbooks support these facts, including *Biological Principles in Modern Practice of Obstetrics*, *Developmental Anatomy*, *Foundations of Embryology*, *Embryology and Teratology*, *Langman’s Medical Embryology*, and others that she cited in her expert report. 10/15/25 PM Tr. at 44:2–7 (Wubbenhorst). These texts show that “the embryo and fetus are human” and that “fetal and embryonic life are part of a continual human life.” 10/15/25 PM Tr. at 44:8–12 (Wubbenhorst). The disclosure is also relevant, since the Coleman and Reardon studies showed that whether women were aware that the fetus was a living human being and not a “clump of cells” was correlated with their attitudes toward abortion. 10/15/25 PM Tr. at 45:22–46:9 (Wubbenhorst).

162. Dr. Curlin testified that the WRTKA’s disclosure that the abortion “will terminate the life of a whole, separate, unique, living human being” is “scientifically uncontested.” 10/16/25 PM Tr. at 24:13–19 (Curlin). This disclosure is a “scientifically accurate description,” regardless of the question of personhood. 10/16/25 PM Tr. at 27:13–28:8, 29:20–30:3 (Curlin). And Dr. Wynia admitted that this disclosure “reflects one of those views that credentialed bioethicists hold,” including Dr. Curlin, who Dr. Wynia knows well and “respects his thinking.” 10/14/25 PM Tr. at 23:12–14 (Wynia).

163. Kansas women who sought abortions were not told this fact, but they wish they had been. 10/15/25 AM Tr. at 41:21–24, 42:7–16 (Cole); 10/14/25 PM Tr. at 141:5–12 (Hoyle); 10/15/25 AM Tr. at 82:7–22 (Pond).

**J. Obligation of father.**

164. Plaintiffs proffered no direct or hearsay evidence that the disclosure about the obligation of the father required by K.S.A. 65-6709(b)(3) caused any

patient harm or requires disclosure of information that is supported by an adequate scientific basis.

165. Dr. Alsaden testified that this disclosure harms patients because its “language about fathers” is stigmatizing and because “father is a social construct.” 9/26/25 PM Tr. at 132:15–19 (Alsaden). But Dr. Alsaden acknowledged that there was no scientific basis for this opinion. 9/29/25 AM Tr. at 40:7–14 (Alsaden). Dr. Alsaden testified that Dr. Alsaden did not use any particular methodology to conclude that this disclosure was harmful and could not render an opinion as to the risk of harm to patients from this disclosure. 9/26/25 PM Tr. at 133:22–134:6 (Alsaden). In addition, Dr. Nauser acknowledged that it “could be important information to know that by law, the father of the child is responsible financially to assist.” Nauser Dep. 214:17–215:10.

**K. Consent to abortion.**

166. Plaintiffs proffered no direct or hearsay evidence that the disclosure about a woman’s freedom to withhold or withdraw her consent to an abortion required by K.S.A. 65-6709(b)(4) and (k) caused any patient harm or requires disclosure of information that is supported by an adequate scientific basis. Kansas women who had abortions felt coerced to do so and were not informed that this coercion was against the law. 10/15/25 AM Tr. at 43:14–16, 44:5–16, 44:21–45:1 (Cole).

167. Ms. Cole wishes that she had been told she could withhold or withdraw her consent because, she testified, “[w]ith the correct information, I could have made other decisions, but I just didn’t know there were any other options.” 10/15/25 AM Tr. at 43:23–44:4 (Cole); 10/15/25 AM Tr. at 82:23–25, 83:8–12 (Pond); *see also* 10/14/25 PM Tr. at 142:2–4 (Hoyle).

168. Plaintiffs’ experts admit that requiring the physician to “inform the woman that she is free to withhold or withdraw her consent to the abortion at any

time prior to invasion of the uterus” reflects “a basic princip[le] of informed consent.” 9/29/25 PM Tr. at 93:24–94:17 (Sawicki).

**L. Fetal-pain disclosures.**

169. Plaintiffs proffered no direct or hearsay evidence that the disclosure about fetal pain required by K.S.A. 65-6709(b)(6) caused any patient harm or requires disclosure of information that is supported by an adequate scientific basis. On this question, Plaintiffs offered the testimony of Dr. Alsaden, to which Defendants responded with the testimony of Dr. Condic and Dr. Robin Pierucci, and as to which Plaintiffs offered the rebuttal testimony of Dr. Steven Ralston. The Court finds the testimony of Drs. Condic and Pierucci more persuasive than the testimony of Drs. Alsaden and Ralston.

170. Dr. Condic is an embryologist and expert in human neurological development on the faculty of Catholic University. Dr. Condic testified that the Act’s fetal-pain disclosures are all strongly supported by scientific evidence. Dr. Condic testified that fetuses can experience pain well before 20 weeks’ gestation. Dr. Condic testified that the precortical areas of the brain, responsible for emotional processing related to pain, are present in children by 20 weeks. 10/16/25 AM Tr. at 85:12–86:23 (Condic). She testified that, at 8 to 10 weeks’ gestation, a child can experience “nociceptive pain,” or a reflex response to pain. 10/16/25 AM Tr. at 85:13–86:8 (Condic). And by 20 weeks, a child has the precortical structures necessary for a “conscious and emotional response to pain.” 10/16/25 AM Tr. at 86:9–24 (Condic).

171. Dr. Condic further testified that researchers have observed fetuses attempt to evade painful stimuli in a manner that, in any other context, would be interpreted as a response to pain. 10/16/25 AM Tr. at 90:20–91:10 (Condic). Dr. Condic testified that unborn children exhibit every physiological response to pain

one would expect in a nonverbal child outside the womb. 10/16/25 AM Tr. at 88:17–25 (Condic).

172. Defendants also presented the expert testimony of Dr. Robin Pierucci, a neonatologist and expert in fetal development, who testified that, based on her experience and expertise in fetal anatomy, the WRTKA’s disclosures on fetal pain are accurate. Dr. Pierucci testified that fetal brain development allows for the feeling of pain by 20 weeks of gestation, 10/16/25 AM Tr. at 21:11–26:10 (Pierucci). She testified that fetuses at 20 weeks show “measurable, demonstrable, consistent reactions” indicating pain, including “hemodynamic changes” and “the release of measurable amounts of stress hormones.” 10/16/25 AM Tr. at 26:17–27:5 (Pierucci).

173. Dr. Pierucci further testified that multiple studies demonstrate improved outcomes for unborn children who receive pain medication and that the standard of care is to treat or avoid pain in fetuses, 10/16/25 AM Tr. at 29:7–30:3; 36:25–27:7 (Pierucci).

174. Plaintiffs offered the expert testimony of Dr. Alsaden that the fetal pain disclosures are inaccurate based on the “best available evidence.” 9/26/25 PM Tr. at 92:19–25 (Alsaden). But when asked what she meant by the “best available medical evidence,” she did not identify any source or authority. 9/26/25 PM Tr. at 92:23–92:3 (Alsaden).

175. Plaintiffs offered the rebuttal expert testimony of Dr. Steven Ralston. Dr. Ralston is the Division Director for Maternal-Fetal Medicine at George Washington University and a member of the Board of Planned Parenthood of Maryland. It is Dr. Ralston’s opinion that children cannot feel pain until sometime after birth because they lack consciousness before then. 10/17/25 AM Tr. at 115:4–6, 117:15–118:17 (Ralston). Dr. Ralston opined that he could not pinpoint the exact time at which children develop the capacity for pain, but that it may be as early as hours after birth or as late as years after birth. 10/17/25 AM Tr. at 114:4–6; 117:7–

17 (Ralston). Dr. Ralston agreed with Drs. Pierucci and Condic that fetuses exhibit physical signs of pain, that surgical outcomes are improved for fetuses who receive pain medication, and that pain signals are transmitted into the brains of fetuses. 10/17/25 AM Tr. at 120:25–122:22 (Ralston).

176. Information about fetal pain would have been relevant to Kansas women who received an abortion. Ms. Cole and Ms. Hoyle were not told that by 20 weeks, an unborn child has the physical structures necessary to experience pain, but they wish they had been. 10/15/25 AM Tr. at 42:17–20, 43:5–13 (Cole); 10/14/25 PM Tr. at 141:19–142:1 (Hoyle).

**M. Medical-assistance benefits.**

177. Plaintiffs proffered no direct or hearsay evidence that the disclosure about available medical-assistance benefits required by K.S.A. 65-6709(b)(1) caused any patient harm or requires disclosure of information that is supported by an adequate scientific basis. Dr. Nauser does not maintain that there is anything “false” in this disclosure. Nauser Dep. 211:10–212:2.

178. Dr. Wubbenhorst testified that the WRTKA disclosure that “medical assistance benefits may be available for neonatal care” is relevant to the abortion procedure because, according to the Reardon study and in her clinical experience, “it is a frequent reason women give for feeling they need to abort the pregnancy.” 10/15/25 PM Tr. at 50:18–51:3 (Wubbenhorst). Dr. Wubbenhorst opined that the disclosure about medical assistance benefits and the availability of prenatal care is relevant even to women who have received a lethal fetal diagnosis because “the availability of support ... such as perinatal hospice ... has been shown to be associated with better outcomes for parents when they carry their child to term compared with when they terminate their affected pregnancy and abort their child.” 10/15/25 PM Tr. at 51:4–15, 77:10–17 (Wubbenhorst). That opinion on perinatal hospice is supported by articles in the literature written by Dr. Wubbenhorst,

10/15/25 PM Tr. at 62:9–63:8 (Wubbenhorst); DX166, and by Drs. Nora Sullivan and Eoghan de Faoite. 10/15/25 PM Tr. at 74:15–75:5 (Wubbenhorst); DX171.

179. Ms. Cole was not given any information about medical-assistance benefits for prenatal care, childbirth, or neonatal care, but she wishes she had been. 10/15/25 AM Tr. at 45:19–22, 46:5–8 (Cole).

**N. Other subsection (b) disclosures.**

180. Plaintiffs proffered no direct or hearsay evidence that the other disclosures required by K.S.A. 65-6709(b) caused any patient harm or that they require disclosure of information without an adequate scientific basis.

**O. 30-minute meeting.**

181. The 30-minute meeting required by K.S.A. 65-6709(c) does not injure patients because Plaintiffs proffered no credible evidence that it delays abortions that would otherwise occur earlier or that it requires disclosure of information without an adequate scientific basis.

182. Plaintiffs' expert admitted that the 30-minute waiting period "furthers the patient's autonomy." 9/29/25 PM Tr. at 95:11–96:17 (Sawicki).

183. Comprehensive Health has "no written documentation about alleged harm associated with [the] 30-minute ... waiting period." 9/30/25 AM Tr. at 55:10–23 (Wales). Nor does it have any documentation of any delay in care resulting from the waiting period. 9/30/25 AM Tr. at 56:21–24 (Wales).

184. The average in-clinic wait time at Comprehensive Health is one to three hours for a drug-induced abortion, two to three hours for a procedural abortion at less than 14 weeks' gestation, three to six hours for a procedural abortion at 14 to 18 weeks' gestation, and six hours for a procedural abortion at greater than 18 weeks' gestation. 10/16/25 AM Tr. at 6:22–7:5 (Sandoval).

185. Dr. Alsaden testified that Dr. Alsaden “cannot recall a patient that did not get an abortion because of – specifically because of the 30-minute waiting period.” Alsaden Dep. 207:2–6.

186. Plaintiffs have observed patients changing their minds about obtaining an abortion during the 30-minute waiting period. 9/29/25 AM Tr. at 21:22–22:2 (Alsaden). Dr. Nauser testified that she has seen patients decide they “would not proceed” with an abortion during the 30-minute waiting period. 9/26/25 PM Tr. at 25:19–26:3 (Nauser); Nauser Dep. 94:21–95:17. She was unable to quantify how often this happened and did not produce any documents that would show how often this happens. Nauser Dep. 94:21–95:17; 9/26/25 PM Tr. at 29:22–30:6 (Nauser). As Dr. Nauser spoke with women during the 30-minute waiting period, they would “give [her] cues that they might not be sure about their decision,” such as saying they were “sad,” “scared,” or “upset.” 9/26/25 PM Tr. at 26:4–17 (Nauser). That would “cue” Dr. Nauser to “look a little further.” 9/26/25 PM Tr. at 26:4–17 (Nauser). Patients also explained why they were not sure about their decision. 9/26/25 PM Tr. at 26:18–27:19 (Nauser).

187. The State of Kansas is ethically justified in requiring a woman to meet with the abortion-providing physician 30 minutes before the abortion to ensure her questions are answered. 10/16/25 PM Tr. at 49:14–18 (Curlin). This requirement gives the woman “another moment ... to ask the abortion provider any questions that she has after her own review of the informed consent materials” for “an irreversible procedure,” and “[o]ne more opportunity ... to really consider whether this is what she wants to do.” 10/16/25 PM Tr. at 32:23–33:14 (Curlin).

188. Kansas women who sought abortions were not given the chance to meet privately with a doctor and ask questions at least a half hour beforehand but wish they had been. 10/15/25 AM Tr. at 37:21–24, 38:7–15 (Cole); 10/14/25 PM Tr. at 139:5–17 (Hoyle); 10/15/25 AM Tr. at 78:14–16, 79:14–22 (Pond).

**P. Pre-payment prohibition.**

189. Plaintiffs proffered no direct or hearsay evidence that the pre-payment prohibition of K.S.A. 65-6709(g) caused any patient harm and they still do not require pre-payment even under the Court's injunction. 9/30/25 AM Tr. at 65:6–9 (Wales).

**Q. Ultrasound.**

190. Plaintiffs proffered no direct or hearsay evidence that the ultrasound requirement of K.S.A. 65-6709(h) caused any patient harm and they continue to perform ultrasounds. Alsaden Dep. 139:7–16; 9/29/25 AM Tr. at 31:4–8 (Alsaden); Nauser Dep. 207:14–24, 227:18–229:12.

191. Kansas women who sought abortion wish they would have received an opportunity to view ultrasound images beforehand. 10/15/25 AM Tr. at 32:14–16, 34:18–24 (Cole); 10/14/25 PM Tr. at 137:7–14 (Hoyle); 10/15/25 AM Tr. at 78:17–19, 79:14–22 (Pond).

**R. Heartbeat requirement.**

192. Plaintiffs proffered no direct or hearsay evidence that the heart-monitoring requirement of K.S.A. 65-6709(h) caused any patient harm and they do not use heart-monitoring equipment. 9/30/25 AM Tr. at 66:16–19 (Wales); 9/29/25 AM Tr. at 13:13–16 (Alsaden); 9/26/25 PM Tr. at 35:12–14 (Nauser).

193. Kansas women who sought abortion were not given an opportunity to hear their unborn child's heartbeat but wish they had been. 10/15/25 AM Tr. at 34:25–35:5 (Cole); 10/14/25 PM Tr. at 137:17–19 (Hoyle); 10/15/25 AM Tr. at 80:13–81:22 (Pond).

**S. Signage requirements.**

194. Plaintiffs proffered no direct or hearsay evidence that the signage requirements of K.S.A. 65-6709(k) and (l) caused any patient harm or that they require disclosure of information without an adequate scientific basis. Further, Dr.

Nauser viewed the signage “as the message of the state of Kansas.” 9/26/25 AM Tr. at 125:18–126:8 (Nauser); *see also* PX112.

**T. KDHE pamphlet.**

195. Plaintiffs proffered no direct or hearsay evidence that the KDHE pamphlet required by K.S.A. 65-6709(d) and 65-6710 caused any patient harm or requires disclosure of information that is supported by an adequate scientific basis.

196. As to the pamphlet’s disclosures on available services, Planned Parenthood continues to provide information about available services to assist women through pregnancy, childbirth, and while their children are dependent, even after the Court’s injunction. 9/26/25 Tr. at 72:7–16 (Alsaden); PX49; PX50. Kansas women who sought abortion were not given this information but wish they had been. 10/15/25 AM Tr. at 46:9–47:5 (Cole); 10/14/25 PM Tr. at 142:10–17, 144:10–19 (Hoyle).

197. On the pamphlet’s disclosures on embryology, Defendants offered the expert testimony of Dr. Pierucci, and Plaintiffs offered the rebuttal expert testimony of Dr. Cynthia Daniels, a political science professor. The Court finds the testimony of Dr. Pierucci more persuasive than the testimony of Dr. Daniels.

198. Dr. Daniels’ testimony concerned findings of the Informed Consent Project, which she conducted. 9/30/25 PM Tr. at 95:7–11 (Daniels). Dr. Daniels offered her opinions as a “political scientist” with no medical, biology, or physical-science degrees or any formal medical training, based on the numerical survey responses of “seven specialists in embryological and fetal anatomy.” 9/30/25 PM Tr. at 127:10–128:11, 135:25–138:10 (Daniels). Dr. Daniels does not “know the names of any of the specialists” who gave their opinions, as she “guaranteed anonymity to all of” them. 9/30/25 PM Tr. at 135:25–138:10 (Daniels). And “once the Informed Consent Project was complete, [Dr. Daniels] destroyed all of the identifying

information about the seven specialists [she] recruited,” making it “impossible to find out who they were.” 9/30/25 PM Tr. at 135:25–138:10 (Daniels).

199. The survey “ask[ed] participants to rate each statement on a five-point scale of truth or falsity and a five point scale of nonmisleadingness.” 9/30/25 PM Tr. at 138:11–140:17 (Daniels). For the “truth” scale, “1 was truthful, 2 was more true than false[,] ... 3 was equally true and false[,] 4 was more false than true and 5 was completely false.” 9/30/25 PM Tr. at 138:11–140:17 (Daniels). For the “nonmisleadingness scale,” “1 was completely nonmisleading, 2 was more nonmisleading than misleading[,] ... 3 was equally misleading and nonmisleading[,] 4 was more misleading than nonmisleading and 5 was ... completely misleading.” 9/30/25 PM Tr. at 138:11–140:17 (Daniels). The only feedback Dr. Daniels received from the “experts” was “numbers,” not the “reasoning they used ... to reach their conclusion” or the literature they relied on. 9/30/25 PM Tr. at 140:18–142:16 (Daniels). This method was sui generis. 9/30/25 PM Tr. at 143:9–144:21 (Daniels).

200. The Informed Consent Project is not a reliable method to determine whether medical statements in the embryology pamphlet are accurate. It does not allow the Court to determine which statements are contested, why they are contested, who is contesting them, or on what basis they are doing so. Instead, it uses a political scientist to launder the opinions of unidentified embryologists in a way that is impossible to scrutinize. It is not credible.

201. In contrast, Defendants offered the expert testimony of Dr. Pierucci, a neonatologist and expert in fetal development, who testified that the information and pictures contained in the disclosures are accurate and not misleading. Dr. Pierucci identified important fetal developments at different gestational ages and explained how the embryology pamphlet accurately portrays and describes each stage of development. 10/16/25 AM Tr. at 26:17–30:7 (Pierucci). Dr. Pierucci further testified that fetal brain development allows for the feeling of pain by 20 weeks of

gestation and that the standard of care is to treat or avoid pain in fetuses. 10/16/25 AM Tr. at 21:11–26:10, 36:25–37:7 (Pierucci). Dr. Pierucci further testified that it is accurate to state that a fetal heartbeat is a “key medical indicator that an unborn child is likely to achieve the capacity for live birth.” 10/16/25 AM Tr. at 40:18–41:2 (Pierucci).

202. Dr. Alsaden objected to the disclosure that less than 5% of all natural pregnancies end in spontaneous miscarriage after detection of cardiac activity, but Dr. Wubbenhorst testified that this disclosure is accurate and supported by studies by Makrydimas and Tannirandorn. 10/15/25 PM Tr. at 46:7–50:1 (Wubbenhorst); DX164; DX165.

203. Kansas women who sought abortion were not given any information about the development of their children in utero, but they wish they had been. 10/15/25 AM Tr. at 40:9–14, 41:9–20 (Cole); 10/14/25 PM Tr. at 140:18–141:4 (Hoyle).

**U. Emergency-abortions disclosure.**

204. Plaintiffs proffered no direct or hearsay evidence that the emergency-abortion requirement of K.S.A. 65-6711 caused any patient harm, and they do not perform emergency abortions. 9/30/25 AM Tr. at 66:20–67:14 (Wales).

**V. Abortion pill reversal disclosure (H.B. 2264).**

205. Plaintiffs proffered no direct or hearsay evidence that the abortion-pill-reversal disclosures required by K.S.A. 65-6716 would cause any patient harm, and this statute requires disclosure of information that is supported by an adequate scientific basis.

206. K.S.A. 65-6716(b)(1) requires the following disclosure:

NOTICE TO PATIENTS HAVING MEDICATION ABORTIONS THAT USE MIFEPRISTONE: Mifepristone, also known as RU-486 or mifeprex, alone is not always effective in ending a pregnancy. It may be possible to reverse its intended effect if the second pill or tablet has not

been taken or administered. If you change your mind and wish to try to continue the pregnancy, you can get immediate help by accessing available resources.

207. The parties' experts do not dispute that some patients "change their mind about having an abortion after taking mifepristone and want to continue their pregnancy." 09/29/25 AM Tr. at 67:11–68:1 (Schreiber); PX069 at e33; 10/16/25 PM Tr. at 50:25–51:7 (Curlin) (women might want to know this information). They also do not dispute that mifepristone alone does not always successfully end a pregnancy. 09/29/25 AM Tr. at 100:24–101:1 (Schreiber). And there is no question that organizations offer resources to help women who seek to try to continue their pregnancies after starting the drug-induced-abortion process. 09/29/25 PM Tr. at 34:16–35:2 (Schreiber); 10/14/25 PM Tr. at 132:21–133:7, 134:19–135:13 (Hoyle).

208. The only question, then, is whether scientific support exists for the second sentence of this disclosure: that it may be possible to reverse the intended effect of mifepristone if the patient has not yet taken misoprostol. Notably, this disclosure does "not say[] that it's definitively proven that taking progesterone will reverse the effects of mifepristone." 10/16/25 PM Tr. at 77:1–16 (Curlin); *contra* 10/14/25 AM Tr. 139:4–9 (Wynia) (contending that the disclosure "implies that this is the standard of care"). Defendants contend that there is evidence that, if a woman takes supplemental progesterone soon after taking mifepristone, she may be able to halt the process and continue her pregnancy (also known as "Abortion Pill Reversal"). As Dr. Wynia testified, because doctors "use things off label in clinical practice fairly often," even if there are only "a few case reports, that kind of thing," physicians have "an obligation to say I think this might be of benefit to you," even if it is not yet "the standard of care." 10/14/25 AM Tr. at 138:12–139:3 (Wynia). Plaintiffs, however, contend that there is no reliable evidence that it may be possible to reverse the effect of mifepristone.

209. On this disputed point, Plaintiffs offered the testimony of Dr. Nauser, Dr. Alsaden, Dr. Wynia, and Dr. Courtney Schreiber, an obstetrician-gynecologist and professor at the University of Pennsylvania. 09/29/25 AM Tr. at 51:5–10 (Schreiber). Defendants offered the testimony of Dr. Curlin. The Court finds that Plaintiffs’ expert testimony tends to support the truth of the disputed disclosures and that, to the extent it conflicts with the testimony of Dr. Curlin, Dr. Curlin’s testimony is more persuasive.

210. In evaluating the scientific support that exists for this disclosure, the Court looks to three primary sources of evidence: (1) evidence of biological plausibility, (2) evidence from randomized clinical trials, and (3) evidence from other studies.

**1. Biological plausibility supports the disclosure.**

211. Both Dr. Schreiber and Dr. Curlin evaluated the scientific evidence about abortion pill reversal based on their education, training, and experience. 10/16/25 PM Tr. at 55:14–25 (Curlin). They agreed on many of the key aspects of the science of abortion pill reversal, including how mifepristone and progesterone function. A woman’s body naturally produces progesterone, “a key hormone in supporting a pregnancy.” 09/29/25 AM Tr. at 60:17–61:15, 91:22–24, 92:3–7 (Schreiber). Progesterone levels naturally rise during pregnancy. 09/29/25 AM Tr. at 91:25–92:2 (Schreiber).

212. Drug-induced abortion is a two-step process. It begins with mifepristone, which blocks progesterone’s effects and causes a “breakdown of ... the uterine lining,” “loosening of the ... pregnancy tissue,” “uterine cramping,” and “cervical softening.” 09/29/25 AM Tr. at 60:17–61:15 (Schreiber). Mifepristone carries a black-box warning of serious and sometimes fatal infections or bleeding, and as a result, “is only available through a restricted program called the mifepristone REMS program.” 09/29/25 AM Tr. at 97:12–25, 98:1–6 (Schreiber);

09/29/25 PM Tr. at 5:12–25, 6:5–8, 6:14–18 (Schreiber). Second, typically 24 hours later, the woman takes misoprostol, a prostaglandin which “causes the uterus to contract” and “expulse its contents.” 10/16/25 PM Tr. at 54:11–21, 59:22–60:10 (Curlin); *see* DX177 at 1, 09/29/25 AM Tr. at 60:18–61:2 (Schreiber).

213. Mifepristone “competes with progesterone for ... progesterone receptors.” 09/29/25 AM Tr. at 93:17–19 (Schreiber). It is a “progesterone receptor antagonist,” which means it “binds to the progesterone receptor in the cells and ... blocks progesterone from doing that same binding.” 09/29/25 AM Tr. at 60:17–61:15 (Schreiber); 10/16/25 PM Tr. at 54:11–21, 59:22–60:10 (Curlin); *see* DX177 at 1. An “agonist” is “the hormone that is fitted to that receptor and which activates a series of downstream actions.” 10/16/25 PM Tr. at 60:11–19 (Curlin); *see* DX177 at 2. A “competitive antagonist” is a “drug or substance that has its effect by competing at a receptor with the normal agonist for that receptor.” 10/16/25 PM Tr. at 60:11–19 (Curlin); *see* DX177 at 2. In a “healthy woman who has not taken mifepristone, ... the agonist progesterone would activate in the progesterone receptor.” 10/16/25 PM Tr. at 61:7–18 (Curlin); *see* DX177 at 3. But a “competitive antagonist block[s] the effects of the agonist,” so “mifepristone block[s] the effects of progesterone.” 10/16/25 PM Tr. at 61:7–18 (Curlin); *see* DX177 at 3; 09/29/25 AM Tr. at 59:17–60:15 (Schreiber).

214. If a pregnant woman takes mifepristone alone, there are three possible outcomes. 09/29/25 AM Tr. at 62:22–62:8 (Schreiber). One, the abortion could occur, perhaps more slowly. 09/29/25 AM Tr. at 62:22–63:8 (Schreiber). Two, because of the loosening of the uterine lining and detachment of the pregnancy tissue, the embryo or fetus “could stop growing ... but stay in the uterus” and not be expelled. 09/29/25 AM Tr. at 62:22–63:8 (Schreiber). Three, “the woman’s naturally produced progesterone” can “go[] back to activating the progesterone receptor and reverse the effects of mifepristone,” 10/16/25 PM Tr. at 63:11–64:3 (Curlin), and the “pregnancy

could continue” without any apparent effect of the mifepristone, 09/29/25 AM Tr. at 62:22–63:8 (Schreiber). Based on the literature, the general rate of continuing pregnancy after taking mifepristone alone is “about 20 to 40 percent.” 09/29/25 AM Tr. at 62:16–19, 100:17–23 (Schreiber).

215. Scientific evidence suggests that because mifepristone is a competitive antagonist, continuing pregnancy can be made more likely by prescribing additional progesterone. A “competitive antagonist” like mifepristone differs from a “noncompetitive antagonist.” 10/16/25 PM Tr. at 60:20–61:6 (Curlin); *see* DX177 at 3. Once a noncompetitive antagonist “is acting, the agonist can have no effect.” 10/16/25 PM Tr. at 60:20–61:6 (Curlin); *see* DX177 at 3. But a competitive antagonist “can be surmounted by increasing the dosages of the agonist.” 10/16/25 PM Tr. at 60:20–61:6 (Curlin); *see* DX177 at 3. “This “basic principle of pharmacology,” described in multiple sources, “applies to mifepristone.” 10/16/25 PM Tr. at 61:19–62:25 (Curlin); *see* DX177 at 4–5. “[B]y definition mifepristone as a competitive antagonist can be at least partially reversed, or surmounted ..., by increasing the dose of the agonist of the progesterone receptor, which is progesterone itself.” 10/16/25 PM Tr. at 63:1–10 (Curlin).

216. Although Dr. Schreiber believes that it is “unlikely” that supplemental progesterone can reverse mifepristone, she acknowledged that “doesn’t mean it is not possible,” and she is unaware of any studies showing that it is impossible. 09/29/25 PM Tr. at 44:16–45:10 (Schreiber).

## **2. Clinical trials support the disclosure.**

217. At the top of the hierarchy of evidence is the gold-standard “randomized controlled trial,” which is the “best methodology to minimize bias and to exemplify that the intervention being tested is actually the cause of the outcome and not some other variable.” 09/29/25 AM Tr. at 68:8–19 (Schreiber).

218. A randomized clinical trial showed that the administration of progesterone on the first day of a drug-induced abortion is significantly more likely to result in continued pregnancy than administration at a later visit. This fact is acknowledged in ACOG Practice Bulletin No. 225, which states that injection of depot medroxyprogesterone acetate (DMPA), a progesterone derivative, at the time of mifepristone administration “may slightly increase the risk of ongoing pregnancy.” PX069 at e38; 09/29/25 PM Tr. at 38:24–39:22 (Schreiber). The trial found that ongoing pregnancy was more common in patients who received DMPA on the same day as mifepristone compared with those who received DMPA at a follow-up visit. PX069 at e38–e39; 09/29/25 PM Tr. at 39:23–41:2 (Schreiber). ACOG thus recommends counseling about this risk of ongoing pregnancy when using DMPA. PX069 at e39; 09/29/25 PM Tr. at 44:18–25 (Schreiber). Based on this evidence, Dr. Nauser agrees that the studies show the administration of progesterone “on day one of the medication abortion regimen may increase the risk of ongoing pregnancy.” 9/26/25 PM Tr. at 35:22–36:12 (Nauser). This is also evidence that time is of the essence in reversing the effects of mifepristone.

219. The ACOG bulletin’s discussion of continuing pregnancy after DMPA injection supports H.B. 2264’s disclosures about abortion pill reversal. 10/16/25 PM Tr. at 65:24–67:25 (Curlin); *see* PX069 at e38–e39. It confirms that “the biology and pharmacology of mifepristone leads experts to expect that administering ... an analog of progesterone[] at or near the time you administer mifepristone ... may partially reverse the effects of mifepristone[] at the progesterone receptor.” 10/16/25 PM Tr. at 65:24–67:25 (Curlin). And “that’s precisely what happened” in the study the bulletin references, which “found that those who had received this DMPA at the time they received mifepristone had higher rates of ongoing pregnancy than those who did not,” which is “what you would expect understanding the biology and pharmacology of mifepristone and mifepristone.” 10/16/25 PM Tr. at 65:24–67:25

(Curlin). And it confirms that “this is the kind of information a reasonable person would want to know.” 10/16/25 PM Tr. at 65:24–67:25 (Curlin). ACOG says that “women should be informed of this.” 10/16/25 PM Tr. at 65:24–67:25 (Curlin).

220. None of Plaintiffs’ experts addressed the results of this clinical trial cited by ACOG in their expert opinions. Instead, they relied primarily on a study by Dr. Mitchell Creinin and others, titled *Mifepristone Antagonization with Progesterone to Prevent Medical Abortion: A Randomized Controlled Trial*, which enrolled just twelve patients. PX084; 09/29/25 AM Tr. at 79:22–24 (Schreiber); 09/29/25 PM Tr. at 20:16–23 (Schreiber). The study was “designed to ... test ... whether ... giving progesterone to a person who has only taken mifepristone and not ... misoprostol ... would increase the likelihood that the pregnancy would continue” compared to “taking mifepristone alone.” 09/29/25 AM Tr. at 80:2–17 (Schreiber).

221. The authors of the Creinin study declared conflicts of interest. Dr. Mitchell Creinin is a consultant for mifepristone-distributor Danco Laboratories. 09/29/25 PM Tr. at 21:16–22:3 (Schreiber); PX084 at 158. And his co-author, Laura Dalton, is an employee of Planned Parenthood. 09/29/25 PM Tr. at 22:3–8 (Schreiber); PX084 at 158.

222. The Creinin investigators “planned to randomize 40 patients” to be able to adequately test their hypothesis. 09/29/25 AM Tr. at 80:2–17 (Schreiber). But they “were only able to enroll 12 patients” before they “decided ... to stop the study early.” 09/29/25 AM Tr. at 80:18–25 (Schreiber). At that time, four of the six participants (66%) who took progesterone following mifepristone had continuing pregnancies, but only two of the six participants (33%) who took mifepristone without progesterone did. PX084 at 160; 09/29/25 PM Tr. at 24:6–11 (Schreiber). Thus, crediting Creinin’s results would support the disclosure at issue—it “provide[s] evidence suggesting progesterone might be effective in reversing the effects of mifepristone.” 10/16/25 PM Tr. at 68:21–69:21 (Curlin); *see* PX084. Indeed,

the Creinin study authors concluded that “[w]e should not dismiss mifepristone antagonization as impossible.” PX084 at 164; 09/29/25 PM Tr. at 32:8–14 (Schreiber).

223. According to Dr. Schreiber, the Creinin study investigators stopped the study because “they were concerned about safety for the participants,” since three patients “had severe bleeding requiring ambulance transport to the emergency department.” 09/29/25 AM Tr. at 80:18–25 (Schreiber), PX084 at 160. But the only participants who needed medical intervention were two who had taken only mifepristone and not progesterone. *See* 09/29/25 PM Tr. at 29:2–4 (Schreiber). And the patient who had taken progesterone “heavily bled for three hours,” which is “within the range of normal” when completing a medication abortion. 09/29/25 PM Tr. at 27:1–7 (Schreiber); PX084 at 160. She completed the abortion on her own without needing any medical intervention. 09/29/25 PM Tr. at 27:8–10 (Schreiber); PX084 at 160. As Dr. Wynia admitted, because it is only “one patient who did take progesterone and who experienced side effects, ... it’s just not enough data to say anything about the reasons that it happened.” 10/14/25 PM Tr. at 30:2–9 (Wynia); *see also* 10/14/25 PM Tr. at 31:10–19 (Wynia).

224. Dr. Schreiber employed an unreliable double standard in evaluating Creinin. While she contended that its small sample size precluded drawing any conclusions about efficacy, she did not hold back on safety conclusions for the same reason. 09/29/25 AM Tr. at 81:8–17 (Schreiber). She opined that “it sounds the alarm or raises concerns that interrupting the medication abortion regimen may be risky for patients, and that some patients who only take mifepristone alone with or without the progesterone could be at increased risk of heavy bleeding.” 09/29/25 AM Tr. at 82:17–83:3 (Schreiber). She did not attribute this risk to progesterone, but instead argued that “whether or not the patients actually accessed the progesterone, they may be at risk for” bleeding by taking mifepristone without

misoprostol. 09/29/25 AM Tr. at 81:18–82:9 (Schreiber); *accord* 10/16/25 PM Tr. at 71:15–20 (Curlin).

225. Plaintiffs offered the expert testimony of Dr. Alsaden that the available literature indicates that abortion pill reversal may be unsafe. 9/26/25 PM Tr. at 98:23–99:8 (Alsaden). But Dr. Alsaden only reviewed the Creinin article before forming her opinion and did not review the 2018 study by Dr. Delgado. 9/29/25 AM Tr. at 14:2–9, 15:15–21 (Alsaden). An opinion formed on a one-sided view of the evidence is not reliable.

### **3. Other studies support the disclosure.**

226. Although randomized, controlled clinical trials are the gold standard of evidence, “[a] variety of different study designs can inform clinical practice.” 09/29/25 AM Tr. at 101:11–14 (Schreiber). On the next rung in the hierarchy of evidence are “prospective cohort studies” and “retrospective cohort studies.” 09/29/25 AM Tr. at 68:8–19 (Schreiber). “Where there are limitations to performing a randomized trial, large cohort studies may be used instead ... when the rationale for doing so is in alignment with the reason for conducting the study.” 09/29/25 AM Tr. at 102:20–103:3 (Schreiber). “The main study that was used for approval” of mifepristone was a cohort study, not a randomized controlled trial. 09/29/25 AM Tr. at 103:4–9 (Schreiber); *see also* 09/29/25 AM Tr. at 102:16–19 (Schreiber).

227. “In general, the larger the study, the more likely it is to be able to demonstrate an association or causation.” 09/29/25 AM Tr. at 103:10–15 (Schreiber). In Dr. Schreiber’s opinion, “it is highly unlikely that a single study or observation of seven individuals would be a large enough sample size to demonstrate an outcome with confidence.” 09/29/25 AM Tr. at 103:16–20 (Schreiber).

228. In 2012, Drs. George Delgado and Mary Davenport published a case series of six women titled *Progesterone Use to Reverse the Effects of Mifepristone* in the journal *The Annals of Pharmacotherapy*. 09/29/25 AM Tr. at 70:21–71:6, 105:2–

8 (Schreiber); DX136. The article reported the outcomes of “six women who took mifepristone and then were given progesterone” without misoprostol. 09/29/25 AM Tr. at 71:13–72:2, 105:18–21 (Schreiber). “[F]our of the six patients delivered healthy term newborns.” 09/29/25 AM Tr. at 105:22–24 (Schreiber).

229. Dr. Schreiber admitted that the 2012 Delgado study “very well could support further study,” 09/29/25 PM Tr. at 15:24–20:7 (Schreiber), which occurred with a follow-up cohort study by Delgado, *A Case Series Detailing the Successful Reversal of the Effects of Mifepristone Using Progesterone*, in *Issues in Law & Medicine* in 2018. DX133; 09/29/25 AM Tr. at 74:5–15 (Schreiber); 09/29/25 PM Tr. at 6:22–7:4 (Schreiber); 09/29/25 AM Tr. at 74:21–75:5 (Schreiber). This article “present[ed] and analyze[d] a series of women who attempted to reverse the effects of mifepristone by taking supplemental progesterone to determine if the reversal of the effects [of] mifepristone with progesterone is possible and safe.” DX133 at 21. Of the 1,668 subjects, 754 initiated progesterone following mifepristone. DX133 at 25; 09/29/25 PM Tr. at 7:21–8:5 (Schreiber). The authors reported the results of 547 patients who met study criteria. 09/29/25 AM Tr. at 75:22–76:9 (Schreiber); 09/29/25 AM Tr. at 8:6–9 (Schreiber); DX133 at 25. Of those 547 women, 257 (47%) gave birth. DX133 at 25; 09/29/25 PM Tr. at 8:10–12 (Schreiber).

230. While the “overall rate of reversal of mifepristone was 48%,” DX133 at 25–26; 09/29/25 AM Tr. at 78:5–9 (Schreiber), those who received progesterone intramuscularly had a 64-percent success rate, DX133 at 26; 09/29/25 PM Tr. at 8:15–18 (Schreiber), and those who received high-dose progesterone orally had a 68-percent success rate. DX133 at 26; 09/29/25 PM Tr. at 8:19–21 (Schreiber). Compared to a historical control of 25 percent, which is “within the 20 to 40 percent range that is supported by the literature.” 09/29/25 PM Tr. at 9:5–13 (Schreiber), the study found “a statistically significant difference in survival between treatment groups and the historic control.” 09/29/25 PM Tr. at 9:20–24 (Schreiber). This study

supports the law's disclosure because it is "consistent with the claim that it may be possible to reverse the effects of mifepristone if one has not taken misoprostol." 10/16/25 PM Tr. at 89:23–90:3 (Curlin).

231. Dr. Schreiber opined that she couldn't "draw any conclusions" on "whether medication abortion reversal is effective" from the 2018 Delgado study. 09/29/25 AM Tr. at 79:10–15 (Schreiber). But this was based on an elementary math error—she said the overall reversal rate of "48 percent is not outside the range" of the "20 to 40 percent of pregnancies [that] can continue to grow after use of mifepristone." 09/29/25 AM Tr. at 78:10–79:5 (Schreiber). Of course, 48 percent is greater than 40 percent. *See* 09/29/25 PM Tr. at 9:13–14 (Schreiber). Dr. Schreiber' also incorrectly testified that "every individual" in this study "already had the outcome before the study started" because having "a living embryo prior to the first progesterone dose" was supposedly part of the "inclusion criteria." 09/29/25 AM Tr. at 76:10–77:4 (Schreiber). The article clearly states that the study included women "who started progesterone therapy prior to sonographic documentation that the embryo was alive," DX133 at 29, and a confirmed viable pregnancy was not in the inclusion criteria, DX133 at 25. Finally, she testified that "it is unclear if any of these patients were consented," 09/29/25 PM Tr. at 11:20–12:5 (Schreiber), but the article stated the opposite, DX133 at 24.

232. Based on the foregoing, the Court concludes that reliable scientific evidence exists to support the claim that it may be possible to reverse the intended effect of mifepristone if misoprostol has not been taken or administered.

**W. H.B. 2749.**

233. Plaintiffs proffered no direct or hearsay evidence that asking women the primary reason for an abortion would cause any patient harm, their expert evidence was not persuasive, and they failed to show that it requires any disclosure of false information.

234. To begin, Plaintiffs are not injured by H.B. 2749 because they already ask questions of the same type as those required by the law. Dr. Sandoval testified that every patient who receives an abortion at Comprehensive Health is asked about “relationship, violence, reproductive coercion. Those things are directly asked of the patient.” Sandoval Dep. 101:13–21. She also testified that “specific, formal questions” are asked of patients regarding coercion, Deposition of Selina Sandoval, M.D., p. 103:17–25, specifically, whether “anyone has ever physically or sexually abused them,” Sandoval Dep. 181:13–25.

235. Plus, as Dr. Wynia previously testified, “it is a totally ordinary situation to have the conversation with the patients about the reasons they are seeking treatment.” 10/14/25 PM Tr. at 38:10–24 (Wynia). And unless “the patient asks ... not to record it, if the patient told [Dr. Wynia] what her highest priority was, [he] would write that down in the record to help the future provider.” 10/14/25 PM Tr. at 39:22–40:1 (Wynia). Indeed, when physicians “ask questions to evaluate whether the patient is making an autonomous decision,” they “often document that in the medical records.” 10/14/25 PM Tr. at 12:21–13:2 (Wynia).

236. In addition, Dr. Wubbenhorst opined that H.B. 2749 “helps to collect data ... which has public health significance and is helpful in public activities.” 10/15/25 AM Tr. at 103:16–20 (Wubbenhorst). Dr. Wubbenhorst is well qualified to testify on these public health matters, having served as second-in-command at the United States Agency for International Development (USAID)’s Bureau for Global Health, the largest global-health-assistance agency in the world. 10/15/25 AM Tr. at 94:17–95:4 (Wubbenhorst); DX117 at 2. There, she oversaw the design and implementation of research projects, health-services delivery, and the distribution of health-related commodities—particularly for maternal and child health and infectious diseases. 10/15/25 AM Tr. at 94:17–95:4 (Wubbenhorst). She also holds a master’s degree in public health from Harvard University, 10/15/25 AM Tr. at

92:14–93:1 (Wubbenhorst); DX117 at 1, and she has been involved in public health surveillance during her time at a community health center in Boston and during her time at the Veterans Administration, which has “one [of the] best public health surveillance systems in the world.” 10/15/25 PM Tr. at 103:22–104:11, 105:4–23 (Wubbenhorst).

237. Dr. Wubbenhorst testified that she and her colleagues frequently ask the reasons why a patient is seeking an elective procedure and that asking these questions is part of the standard of care. 10/15/25 PM Tr. at 53:6–14 (Wubbenhorst). It is part of the standard of care in obstetrics and gynecology to ask about patients’ psychosocial health and risks. 10/15/25 PM Tr. at 55:6–14 (Wubbenhorst). And a patient’s reason for a procedure may be relevant to the procedure. 10/15/25 PM Tr. at 53:18–54:16 (Wubbenhorst). For example, Dr. Wubbenhorst saw a patient who requested surgery on her labia, and the patient’s reason—that “her boyfriend wanted them to look more like what he saw on pornography”—was an “inappropriate potential indication to do an invasive procedure.” 10/15/25 PM Tr. at 53:21–54:19 (Wubbenhorst).

238. The reasons a patient seeks an abortion may be relevant to whether a doctor will perform it. 10/15/25 PM Tr. at 54:20–55:5 (Wubbenhorst). For example, the abortion arranged by a teacher on a minor whom he had impregnated under conditions of statutory rape was “clearly inappropriate.” 10/15/25 PM Tr. at 54:20–55:5 (Wubbenhorst). An abortion requested for sex selection, which is illegal, is another example. 10/15/25 PM Tr. at 54:20–55:5 (Wubbenhorst).

239. The evidence shows that state surveillance of the reasons women seek abortion is quite common. Fourteen states collect data on reasons for abortion, including states like Washington, New York, and New Jersey. 10/15/25 PM Tr. at 55:21–56:6 (Wubbenhorst). Some states, like Arizona, collect much more detailed information than H.B. 2749 does. 10/15/25 PM Tr. at 55:21–56:6 (Wubbenhorst).

Washington state says that “the collection of data for public health surveillance serves important public health functions in helping to understand the number of procedures, the types of procedures, their potential complications, women who are seeking abortion, [and] how increasing contraceptive access may decrease rates of abortion.” 10/15/25 PM Tr. at 57:8–17 (Wubbenhorst).

240. Dr. Wubbenhorst opined that the collection of data on the reasons that a woman seeks an abortion “does not affect the woman herself.” 10/15/25 PM Tr. at 58:23–59:2 (Wubbenhorst). “[I]f she [is] being asked questions that she does not wish to answer, she’s not compelled to answer those questions.” 10/15/25 PM Tr. at 58:23–59”7 (Wubbenhorst). Instead, asking these questions “potentially helps women” by helping “identify situations of coercion, child sex abuse, ... adult sex abuse[,] and domestic violence.” 10/15/25 PM Tr. at 59:8–15 (Wubbenhorst).

241. Plaintiffs offered the expert testimony of Dr. Lisa Lee, a public health ethicist. 9/30/25 PM Tr. at 22:4–6 (Lee). Dr. Lee reasons that H.B. 2749 is not methodologically or ethically consistent with public health surveillance because it lacks what she calls an “*a priori* purpose.” 9/30/25 PM Tr. at 68:7–69:2 (Lee). However, even assuming that public health ethics had bearing on the constitutionality of H.B. 2749, particularly when many other states collect the same data, Dr. Lee’s testimony suffers from a fatal flaw: she failed to consider dispositive evidence of H.B. 2749’s *a priori* purpose.

242. Dr. Lee acknowledged that H.B. 2749’s *a priori* purpose could be revealed through legislative “committee testimony,” even if that purpose is “not listed explicitly in the text of the bill.” 9/30/25 PM Tr. at 70:14–73:8 (Lee). But Dr. Lee “didn’t look at any legislative committee testimony until it was shown to [her] at [her] deposition.” 9/30/25 PM Tr. at 70:14–73:8 (Lee). She did not “ask for any committee testimony before [she] prepared either of [her] two expert reports in this case.” 9/30/25 PM Tr. at 73:9–75:19 (Lee). Dr. Lee also testified that it “would have

been relevant if abortion providers were consulted during the deliberative process,” including “Planned Parenthood Great Plains.” 9/30/25 PM Tr. at 75:2–15 (Lee).

243. In fact, the legislative record contains all of these things. Proponent testimony noted that “[a]ccurate data is necessary for the establishment of policies and programs that truly address the needs of Kansans. This includes data regarding circumstances that lead to abortions being performed on women.” DX146. Further, “having current data for Kansas is critical to finding ways to alleviate some of the pressures women with unexpected pregnancies face.” DX146. “HB 2749 will help the general public and policy makers gain a better understanding as to why abortions are performed. From there, policies can be crafted to better address the social concerns of women facing such an important decision.” DX146. Other proponent testimony noted that “[u]pdating current abortion reporting requirements from the Kansas Department of Health & Environment (KDHE) as proposed in HB 2749 will help provide policy makers, pregnancy support organizations and the public at large with more timely and improved information about why women choose abortion in Kansas.” DX148 at 1. And Planned Parenthood Great Plains did, in fact, submit committee testimony for H.B 2749 through Dr. Sandoval to the Senate Committee on Public Health and Welfare. *See* HB 2749 Committee Minutes and Testimony, 2023–2024 Kansas Legislative Sessions, [perma.cc/7RUS-936Y](https://perma.cc/7RUS-936Y). Dr. Lee did not offer any testimony explaining why this legislative record, which she did not look at, was insufficient to show any *a priori* purpose the law might require.

244. Former abortion patients, Ms. Cole, Ms. Hoyle, and Ms. Pond, agree that being asked one’s reasons for an abortion is not harmful. Their answers about how they would have responded to H.B. 2749’s question provide insight into various pressures that cause women to choose abortion. Ms. Cole answered that she “didn’t have enough support from family or others to raise a child” for her first abortion,

that she wasn't ready for a baby for the second abortion, and her boyfriend's support for her third abortion. 10/15/25 AM Tr. at 47:25–48:14, , 51:15–20, 52:6–12 (Cole). Ms. Hoyle said she would answer, “The patient does not have enough support from family or others to raise a child.” 10/14/25 PM Tr. at 145:2–11, 146:12–15 (Hoyle). Ms. Pond replied, “I wouldn't have been able to care for children if I ... carried them to term.” 10/15/25 AM Tr. at 87:16–23 (Pond). None of them would have felt hurt or offended by the question. 10/15/25 AM Tr. at 51:12–14 (Cole); 10/14/25 PM Tr. at 146:16–18, 147:2–4 (Hoyle); 10/15/25 AM Tr. at 88:13–17 (Pond).

245. H.B. 2749 “protects maternal health and safety” because in vulnerable and underserved populations, “domestic violence is not only common, it almost invariably tends to escalate.” 10/15/25 PM Tr. at 59:18–61:6 (Wubbenhorst); 10/16/25 PM Tr. at 84:9–12 (Curlin). It promotes respect for prenatal life at all stages of development because “it helps women to understand ... that this is a human being,” which is “contrary to what is often told, that this is a ball of cells.” 10/15/25 PM Tr. at 61:5–14 (Wubbenhorst); 10/16/25 PM Tr. at 85:4–7 (Curlin). And it “protects the integrity of the medical profession because as fiduciaries, [physicians] have a responsibility to [their] patients.” 10/15/25 PM Tr. at 61:17–62:3 (Wubbenhorst).

### **CONCLUSIONS OF LAW**

1. The Court concludes that Plaintiffs have failed to establish third-party standing to challenge the WRTKA on behalf of the rights of current, former, or future patients to autonomy.

2. The Court further concludes that Plaintiffs have failed to prove that the WRTKA or H.B. 2749 infringes any constitutional right or that those laws lack a rational basis.

## **I. Legal standards.**

### **A. Jurisdiction.**

3. The Court must have jurisdiction before it may rule on Plaintiffs' claims at trial. *State v. Berreth*, 294 Kan. 98, 117, 273 P.3d 752, 764 (2012). Plaintiffs have the burden to establish the Court's jurisdiction at every stage of the proceeding with the standard of proof appropriate to that stage. *TransUnion LLC v. Ramirez*, 594 U.S. 413, 431 (2021); *Gannon v. State*, 298 Kan. 1107, 1124, 319 P.3d 1196, 1211 (2014). They therefore must prove the facts establishing the Court's jurisdiction at trial by a preponderance of evidence. *Gannon*, 298 Kan. at 1124, 319 P.3d at 1211.

4. Plaintiffs' claims on behalf of their patients require them to establish the elements of third-party standing. *Landrith v. Jordan*, 308 P.3d 31, 2013 WL 5187269, at \*8 (Kan. App. 2013) (unpublished). As a matter of Kansas law, this requires them to show that (1) Plaintiffs have their own injury; (2) Plaintiffs have a close relationship with their patients; and (3) obstacles exist to their patients bringing suit on their own behalf. *Id.*; *Powers v. Ohio*, 499 U.S. 400, 410–11 (1991); *Kowalski v. Tesmer*, 543 U.S. 125, 131 (2004). In addition, as a matter of federal due process, they must show that their interests in this case do not conflict with the interests of their patients whose rights they seek to adjudicate. *Elk Grove Unified Sch. Dist. v. Newdow*, 542 U.S. 1, 15 (2004); *June Med. Servs. LLC v. Russo*, 591 U.S. 299 (2020) (Alito, J., dissenting); *EMW Women's Surgical Ctr., P.S.C. v. Friedlander*, 960 F.3d 785, 813 n.2 (6th Cir. 2020) (Bush, J., dissenting), *opinion vacated on reh'g*, No. 19-5516, 2022 WL 2866607 (6th Cir. July 21, 2022), and *abrogated by Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215 (2022).

### **B. Burden of proof.**

5. Because Kansas courts presume that state laws are constitutional, Plaintiffs have the burden to show beyond a reasonable doubt that a given provision

of the challenged laws infringes a constitutional right. *State v. Engles*, 270 Kan. 530, 531, 17 P.3d 355, 358 (2001); *State v. Robinson*, 303 Kan. 11, 278, 363 P.3d 875, 1050–51 (2015). “A reasonable doubt is a fair doubt based on reason and common sense and arising from the state of the evidence”; “suspicion or conjecture” is insufficient. *State v. Finley*, 273 Kan. 237, 249, 42 P.3d 723, 732 (2002).

**C. Facial challenge.**

6. In addition, because Kansas courts disfavor facial challenges like this one, Plaintiffs must show that “no set of circumstances exists under which the Act would be valid.” *State v. Jones*, 313 Kan. 917, 931, 492 P.3d 433, 445 (2021); *see also State v. Hall*, 65 Kan. App.2d 369, 389, 564 P.3d 786, 799 (Kan. Ct. App. 2025) (applying facial standard to actual infringement test).

**D. Severability.**

7. The Challenged Statutes are severable to the extent that they can still serve their intended purpose if any unconstitutional provision is excised from the law. If Plaintiffs prove that a provision of a challenged law violates the Kansas constitution, only that provision is invalid unless Plaintiffs overcome the “strong presumption” that the challenged law is severable. *Barr v. Am. Ass’n of Pol. Consultants, Inc.*, 591 U.S. 610, 625 (2020); *City of Wichita v. Trotter*, 316 Kan. 310, 321, 514 P.3d 1050, 1058 (2022). To prove lack of severability, Plaintiffs must show that the Legislature did not intend the challenged law to be severable, that it would not have been passed without the unconstitutional provision, and that it is not possible for the Challenged Law to serve its intended purpose without that provision. *Trotter*, 316 Kan. at 321, 514 P.3d at 1058.

**II. Plaintiffs failed to prove third-party standing for the WRTKA claims.**

**A. Plaintiffs did not prove existing relationships with patients.**

8. Plaintiffs lack the ongoing relationship with their patients that third-party standing requires. Third-party standing requires an “*existing*. . . relationship,”

which is “quite distinct from [a] *hypothetical*” relationship. *See Kowalski*, 543 U.S. at 131 (emphases in original). Unlike other doctor-patient relationships, abortion providers rarely “have a close relation[ship]” with their patients; rather, “their relationship is generally brief and very limited.” *June Med.*, 591 U.S. at 402 (2020) (Alito, J., with Thomas & Gorsuch, J.J., dissenting).

9. Plaintiffs produced no evidence of a close, existing relationship with their abortion patients. Instead the evidence at trial showed that large numbers of Plaintiffs’ patients never schedule or attend follow-up appointments. FOF ¶¶ 21, 35, 108, 117. None of Plaintiffs’ patients testified on their behalf and the only testimony from Kansas women who sought abortions showed the absence of an ongoing relationship with their abortion doctor. FOF ¶¶ 74–78, 82–83, 85–90, 93–95, 100–105.

**B. Plaintiffs did not prove obstacles to individual suits.**

10. No obstacles exist that prevent individual suits by affected women. Third-party standing also fails because “[t]here are no ‘insurmountable’ obstacles stopping women seeking abortions from asserting their own rights.” *Whole Woman’s Health v. Hellerstedt*, 579 U.S. 582, 631 (2016) (Thomas, J., dissenting). To the contrary, “interested women have challenged abortion regulations on their own behalf in case after case.” *June Med.*, 591 U.S. at 414 (Gorsuch, J., dissenting) (collecting cases). Justiciability of those cases poses no concern, for “if a woman seeking an abortion brings suit, her claim will survive the end of her pregnancy under the capable-of-repetition-yet-evading-review exception to mootness.” *June Med.*, 591 U.S. at 405–06 (Alito, J., dissenting). Nor is the potential loss of privacy a deterrent to suit, since women “can sue under a pseudonym” and avail themselves of “[o]ther precautions [that] may be taken during the course of litigation to avoid revealing their identities.” *June Med.*, 591 U.S. at 406 (Alito, J., dissenting).

11. Plaintiffs have produced no evidence of obstacles to individual suits. To the contrary, other Plaintiffs in Kansas state lawsuits have successfully filed under pseudonyms to challenge the constitutionality of state laws affecting their rights to obtain specific medical procedures. *See, e.g., Loe v. Kansas*, DG-2025-CV-000241 (Kan. Dist. Ct., Douglas County 2025) (patient challenge to Kansas Help Not Harm Act); *Vernon v. Kobach*, DG-2025-CV-000252 (Kan. Dist. Ct., Douglas County 2025) (patient challenge to Kansas Natural Death Act). Plaintiffs made no attempt to show obstacles to doing so here.

**C. Plaintiffs did not prove their interests align with patients.**

12. Plaintiffs' interests conflict with those of the women they claim to represent. "When an abortion regulation is enacted for the asserted purpose of protecting the health of women, an abortion provider seeking to strike down that law should not be able to rely on the constitutional rights of women." *June Med.*, 591 U.S. at 402 (Alito, J., dissenting). Such a conflict would violate due process by deciding the rights of Plaintiffs' patients without joining them as parties or giving them adequate representation. *Amchem Prods., Inc. v. Windsor*, 521 U.S. 591, 625–26 (1997).

13. That conflict is readily apparent for Plaintiffs' challenge of the WRTKA. For one, they purport to invoke the rights of their patients to invalidate a law that gives those same patients the right to sue them. FOF ¶¶ 1–3. And for another, they have a pecuniary interest in minimizing informed consent to maximize total patients seen, while each patient individually has an interest in ensuring they receive appropriate disclosure. FOF ¶¶ 45, 79, 81, 83, 90, 98, 105, 107, 134–135, 138, 144, 148, 150, 152, 163, 166–67, 176, 178–179, 182, 187–188, 191, 193, 196, 203, 207. That conflict of interest is reinforced by the complaints of Plaintiffs' patients regarding the lack of informed consent and by the testimony of Kansas women on the lack of information they received when they sought an

abortion. FOF ¶¶ 76, 81–83, 89–90, 93, 98, 100, 103, 105, 122. Just as in *June Medical*, “it’s pretty hard to ignore the potential for conflict here,” 591 U.S. at 415 (Gorsuch, J., dissenting), and Plaintiffs have produced no evidence showing otherwise.

### **III. Plaintiffs failed to prove the WRTKA infringes a constitutional right.**

14. To prove infringement of their patients’ right to bodily autonomy, Plaintiffs must show beyond a reasonable doubt that a provision of the challenged laws “actually infringes” a woman’s right “to decide whether to continue a pregnancy.” *Hodes & Nauser, MDs, P.A. v. Stanek*, 318 Kan. 995, 1005, 551 P.3d 62, 71 (2024) (*Hodes III*); *Hodes & Nauser, MDs, P.A. v. Schmidt*, 309 Kan. 610, 620, 440 P.3d 461, 471 (2019) (*Hodes I*). To do so, Plaintiffs must prove beyond a reasonable doubt that the provision “constrain[s],” “interfere[s]” with, or “restrict[s]” a woman’s ability to terminate or continue her pregnancy. *Hodes I*, 309 Kan. at 646, 667, 440 P.3d at 484, 496. That a provision “appears” to impair autonomy is “not enough.” *Hodes III*, 318 Kan. at 1008, 551 P.3d at 73.

15. Plaintiffs’ evidence purporting to show that the WRTKA’s informed consent requirements are inconsistent with a purported national standard of care does not prove infringement. This is so because the standard of care is determined by state law. *See Foster ex rel. Foster v. Klaumann*, 296 Kan. 295, 299, 304, 294 P.3d 223, 227, 230 (2013); *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996) (holding that regulating the practice of medicine is one of “the historic police powers of the States” that federal law is presumed not to displace). State standards of care are typically a matter of common law developed through tort lawsuits and “established by the testimony of competent medical experts.” *Biglow v. Eidenberg*, 308 Kan. 873, 893–94, 424 P.3d 515, 529 (2018). Plaintiffs’ experts acknowledge that states may supersede those common-law standards of care by statute. FOF ¶ 48. Thus, Kansas law imposes statutory informed consent requirements for a variety of medical

procedures, setting the standard of care for the administration of “psychotropic medication,” K.A.R. 28-39-231; dry needling, K.A.R. 100-29-19; weight-loss medication, K.A.R. 100-22-8a; and many others. *See* State Defs. Opp. to MSJ at 45 n.4.

16. Because the WRTKA sets the controlling standard of care in Kansas, evidence of position statements from national organizations does not and cannot set a controlling legal standard. “[T]he Constitution does not require ... States to view these treatments in the same way as the majority of experts.” *L.W. v. Skrmetti*, 83 F.4th 460, 478 (6th Cir. 2023). “Useful as [such] principles may be to the medical profession,” they do not dictate the limits of how the state may regulate that profession. *Id.* Nor do they somehow reflect a national standard of care.

**A. Plaintiffs did not prove the WRTKA infringes autonomy.**

17. Plaintiffs did not prove that any provision of the WRTKA infringes their patients’ autonomy.

18. Plaintiffs did not attempt to prove that any provision of the WRTKA other than the paper-format and waiting-period requirements of K.S.A. 65-6709(a) and (c) have resulted in delay or denial of an abortion. FOF ¶¶ 139, 142, 146, 151, 154, 156, 158, 164, 166, 169, 177, 180, 189, 190, 192, 194–195, 204–205.

19. Plaintiffs’ evidence purporting to show that the paper format and 24-hour waiting period requirements of K.S.A. 65-6709(a) caused delay or denial of abortions is insufficient as a matter of law to prove infringement of the right to autonomy. That is because the evidence at trial showed that Plaintiffs had alternate methods of compliance with the WRTKA that would have avoided the problems of delay that they claim. FOF ¶¶ 109–111.

20. Plaintiffs failed to prove that any of the WRTKA disclosures violated the right to autonomy by requiring the disclosure of misleading or irrelevant information. State Defendants established that each of the challenged disclosures—

including the whole, separate, living human being requirement, the fetal pain disclosures, the embryology pamphlet, and the abortion pill reversal disclosures—is supported by reliable scientific evidence and is relevant to the abortion procedure. FOF ¶¶ 58, 158–163, 169–176, 196, 201–203, 207, 211–232. Plaintiffs did not attempt to prove that any other disclosure required by the WRTKA is not supported by scientific evidence.

**B. Plaintiffs did not prove the WRTKA infringes free speech.**

21. To prove infringement of their right to free speech, Plaintiffs must show two elements beyond a reasonable doubt. First, they must show that to comply with the challenged laws, Plaintiffs must speak a message with which they disagree. *West Virginia State Bd. of Educ. v. Barnette*, 319 U.S. 624 (1943). Second, they must show either that the message is false and misleading or is unrelated to a medical procedure that Plaintiffs perform. *Nat’l Inst. of Fam. & Life Advoc. v. Becerra*, 585 U.S. 755, 768–770 (2018); *Planned Parenthood of Se. Pennsylvania v. Casey*, 505 U.S. 833, 882–84 (1992).

**1. The disclosures are true, relevant, and non-misleading.**

22. For the same reasons outlined above that the WRTKA does not violate autonomy by requiring disclosure of information without an adequate scientific basis, it also does not violate free speech. FOF ¶¶ 58, 158–163, 169–176, 196, 201–203, 207, 211–232.

**2. The disclosures are the government’s speech.**

23. The disclosures required by the WRTKA also cannot violate free speech because they are government speech from the State of Kansas. FOF ¶¶ 115–116, 194. Plaintiffs acknowledge that they are conveying the government’s message, which they communicate as such, and that they can and do provide corrective disclosures when they disagree with it. FOF ¶¶ 115–116, 194.

### 3. The disclosures are speech incidental to conduct.

24. In addition, the challenged disclosures do not regulate Plaintiffs' speech based on content or viewpoint but rather regulate Plaintiffs' "professional conduct ... [which] incidentally involves speech." *NIFLA*, 585 U.S. at 768 (citing *Planned Parenthood Se. Pa. v. Casey*, 505 U.S. 833, 884 (1992)). Kansas regulates professional conduct under the State's legitimate authority. Kansas "has a right to regulate, through its agencies, the practice of medicine." *Corder v. Kansas Bd. of Healing Arts*, 256 Kan. 638, 654, 889 P.2d 1127 (1994). Informed consent requirements are incidental to the regulation of medical "conduct" if they meet three conditions: (1) the regulation must be "tied to a procedure;" (2) the procedure must be "sought, offered, or performed;" and (3) the regulation must carry information about the "risks or benefits of those procedures." *NIFLA*, 585 U.S. at 770.

25. All three of those conditions are met here—the evidence establishes that each disclosure is relevant to the procedure, FOF ¶¶ 58, 140, 143, 147–148, 150, 152, 163, 165, 167, 176, 178–179, 191, 193, 196, 203; the procedure is offered by Plaintiffs, FOF ¶¶ 5, 10; and the information about the procedure is scientifically supported and thus truthful and non-misleading. FOF ¶¶ 58, 143, 159–162, 170–173, 175, 177, 201, 202, 207, 211–232.

### 4. H.B. 2264 is not unconstitutionally vague.

26. To prevail on their claim that H.B. 2264 is unconstitutionally vague, Plaintiffs must show beyond a reasonable doubt that the law does not "give a person of ordinary intelligence a reasonable opportunity to know what conduct is [required]" or lacks "explicit standards for its enforcement" to "prevent arbitrary and discriminatory enforcement." *State v. Black 1999 Lexus ES300*, 45 Kan. App. 2d 168, 176, 244 P.3d 1274, 1280 (2011). Plaintiffs did not introduce any evidence at trial supporting this claim.

**C. Plaintiffs did not prove the WRTKA infringes equal protection.**

27. To prove infringement of their patients' right to equal protection, Plaintiffs must show beyond a reasonable doubt that a provision of the challenged law imposes a classification that "result[s] in arguably indistinguishable classes of individuals being treated differently." *Miami Cnty. Bd. of Comm'rs v. Kanza Rail-Trails Conservancy, Inc.*, 292 Kan. 285, 315, 255 P.3d 1186, 1207 (2011). Because "only women can have an abortion," "men and women are not similarly situated when it comes [to] pregnancy and abortion." *Planned Parenthood Great Nw. v. State*, 522 P.3d 1132, 1198 (Idaho 2023); *Dobbs*, 597 U.S. at 236. Thus, proving an equal-protection violation in this context requires showing beyond a reasonable doubt that the statute is a "mere pretext[t] designed to effect an invidious discrimination against members of one sex or the other." *See Dobbs*, 597 U.S. at 236; *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263, 273–74 (1993). No Kansas or federal court has ever found that a statute regulating abortion constitutes an infringement of a fundamental right for equal protection purposes.

28. Regulation of a procedure that only one sex can undergo does not violate equal protection. "[B]ecause men and women are not similarly situated when it comes to pregnancy and abortion. Only women are capable of pregnancy; thus, only women can have an abortion. This is not sex-based discrimination against women any more than a law regulating unlicensed vasectomies or prostate treatments would be discriminatory against men." *Planned Parenthood Great Nw. v. State*, 522 P.3d 1132, 1198 (Idaho 2023); *Caban v. Mohammed*, 441 U.S. 380, 398 (1979) (Stewart, J., dissenting) ("When men and women are not in fact similarly situated in the area covered by the legislation in question, the Equal Protection Clause is not violated."). Indeed, "a State's regulation of abortion is not a sex-based classification and is thus not subject to the 'heightened scrutiny' that applies to such classifications." *Dobbs*, 597 U.S. at 236. Nor did Plaintiffs adduce any evidence

that the WRTKA “mere pretext[t] designed to effect an invidious discrimination against members of one sex or the other.” *Dobbs*, 597 U.S. at 236.

29. Plaintiffs also failed to prove that the WRTKA is impermissibly infected by sex stereotypes. The only evidence they introduced on this point was the testimony of Dr. Syrett, which the Court found non-persuasive. FOF ¶¶ 124–126. These claims therefore fail.

**IV. Plaintiffs failed to prove H.B. 2749 infringes a constitutional right.**

**A. Plaintiffs did not prove H.B. 2749 infringes autonomy.**

30. H.B. 2749 does not violate autonomy because Plaintiffs adduced no credible evidence that it will prevent or delay abortions. The only purported evidence of harm to autonomy that Plaintiffs introduced on this point was the testimony of Dr. Kimport on stigma from abortion restrictions, which the Court found not persuasive. FOF ¶¶ 124, 127–128. These claims therefore fail.

**B. Plaintiffs did not prove H.B. 2749 infringes free speech.**

31. H.B. 2749 does not violate free speech because it can be implemented without compelling any speech from Plaintiffs. Because Plaintiffs bring a facial, pre-enforcement challenge to H.B. 2749, they must show that “no set of circumstances exists under which the Act would be valid” through any method of enforcement. *Jones*, 313 Kan. at 932, 492 P.3d at 445. Plaintiffs did not meet this burden: H.B. 2749 could be enforced without any speech at all by Plaintiffs through a KDHE form asking patients the required questions.

32. Even if H.B. 2749 compelled speech, it would be speech incidental to conduct. The speech is relevant to a procedure that Plaintiffs perform and, because it consists of a question, it is truthful and non-misleading. FOF ¶¶ 5, 10.

**C. Plaintiffs did not prove H.B. 2749 infringes equal protection.**

33. For the same reasons noted above, regulation of a procedure that only one sex can undergo does not violate equal protection.

**V. The WRTKA and H.B. 2749 satisfy constitutional scrutiny.**

34. If Plaintiffs fail to prove beyond a reasonable doubt that a provision of a challenged law infringes a constitutional right, the provision is constitutional so long as a rational basis for it exists. This “very lenient standard” requires the Court to uphold the provision so long as it perceives any state of facts rationally related to a legitimate government interest. *State v. Genson*, 59 Kan. App. 2d 190, 212, 481 P.3d 137, 154 (2020), *aff’d*, 316 Kan. 130, 513 P.3d 1192 (2022). State Defendants have “no obligation to produce evidence or empirical data,” and Plaintiffs must “negative every conceivable basis” under which the provision might be upheld. *Id.*

35. Defendants introduced evidence that both the WRTKA and H.B. 2749 support valid state interests in protecting maternal health and safety, protecting fetal life, and upholding the integrity of the medical profession. These laws therefore satisfy constitutional scrutiny.

**CONCLUSION**

Based on the foregoing, the Court hereby concludes that Plaintiffs have not met their burden to establish (1) that the Court has jurisdiction over their third-party claims challenging the WRTKA; or (2) that any provision of the WRTKA, H.B. 2264, or H.B. 2749 infringes on any right under the Kansas constitution. The Court therefore vacates its temporary injunction and the parties’ so-ordered stipulation as to H.B. 2749 and directs the entry of judgment for Defendants dismissing this case with prejudice.

\* \* \* \*

Pursuant to Local Rule 3.7, the undersigned hereby certifies that no portion of the State Defendants’ Proposed Findings of Fact and Conclusions of Law was drafted/prepared using Generative A.I.

December 15, 2025

Respectfully submitted,

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